Homerton Healthcare NHS Foundation Trust
Quality Account Report
2022/23

INTRODUCTION

The aim of this report is to provide a review of the quality of the care and the services that are delivered by the Homerton Healthcare NHS Foundation Trust, previously known as Homerton University Hospital NHS Foundation Trust. Once again, the Trust acknowledges that the content and wording used within this document may appear bureaucratic and uncompassionate, but the report is written in a manner that complies with our statutory duty under the Health Act 2009 and the National Health Service Regulations.

The reporting period covered within this quality account report is for the 2022/23 financial year (1st April 2022 to 31st March 2023).

The Trust welcomes this opportunity to communicate our continued progress and commitment to key elements of delivering high quality care; -

- Patient Safety,
- Clinical Effectiveness, and
- Patient Experience.

1.0 PART 1: STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE OF THE NHS FOUNDATION TRUST

The annual Quality Account gives us an opportunity, each year, to reflect on our achievements and to openly share our performance and outcomes for public scrutiny. I've been reflecting on what an extraordinary year it has been. For the thousands of patients that have come both into our community services and into our hospitals we have continued to keep focused and make progress on all our key safety and quality priorities.

Within this report you will find the priorities set by the Trust Board for 2022 to 2024 together with the results and achievements for 2022/23. There are priorities set in Patient Safety, Safe and Effective and Patient Experience. As we are in the middle of our two-year cycle, we have reported partial achievement. We have identified ongoing actions going into 2023/24 to help us achieve our ambitions.

Our patient safety priorities are:

- To reduce the number of community and hospital attributed pressure ulcers,
- Reducing physical violence and aggression towards patients and staff and
- Improved management and reduction in the rate of falls.

We have a priority that cuts across both safe and effective priority:

- Just Culture and Safe Environment.

Our clinical effective priorities are:

- Appropriate identification and management of deteriorating patients, including maternity, paediatrics and community-based services
- Improving our populations health.

Our patient experience priority is to:

- Improve the first impression and experience of the Trust for all patients and visitors.

In Part 3 of this report, a more detailed overview is provided of the progress of each quality priority achieved during 2022/23.

Quality & Patient Care

The impact of the Covid pandemic upon the Trust, our staff and our patients continued to be felt during 2022/23 despite the advancements in vaccination and management of the virus. It is encouraging that Trust continues to perform well against key national and local quality measures as we address the backlog of people awaiting elective care (non-urgent treatment) which developed during the initial Covid lockdowns.

The Trust continues to perform well against the 4-hour A&E treat/discharge target, remaining to be one of the best performing trusts nationally We continue to meet standard for monitoring the delivery of seven-day services, meaning that our patients are reviewed and assessed by senior staff whenever that are admitted.

There has been considerable effort to improve the cancer waiting targets with the Trust exceeding both the 2 week and 31-day targets. Performance against the 62-day target remains challenging and significant work to redesign several cancer pathways is underway across the North East London network to improve the patient journey.

The Trust continues to progress action plans developed in response to CQC recommendations and have delivered improved governance within maternity services. These improvements are supported and evidenced by regular audits to ensure the continued safe care of mothers and their babies. Work is also underway to implement a new IT solution that will enhance the accessibility and security of clinical information used within our maternity services.

The Trust continues to demonstrate a healthy incident reporting culture with a high incident reporting rate, ensuring that incidents are appropriately reported, investigated and actions taken where necessary to improve patient safety. Improvements have been made to how lessons learned from investigations are shared across the organisation.

There has been a significant amount of work undertaken towards the implementation of the new Patient Safety Incident Response Framework (PSIRF), which is due to be launched in September 2023. PSIRF replaces the existing Serious Incident Framework and represents a fundamental shift in how incidents are responded to, with a welcomed increased focus on learning and improvement, as well as ensuring that patients and their families are at the heart of our response.

The Trust has appointed the Head of Patient Safety as the Patient Safety Specialist who has attended the Trust Board to talk through their priorities for patient safety. Two Patient Safety Partners have been appointed from the local population they will provide a patient voice at the highest level, as well as speaking with staff and patients on wards.

We continue to report a high number of patient satisfactions despite the increasing demand on our services and the recovery following the pandemic. The Trust acknowledges that on occasions it may not be as responsive as we could be and are currently engaged in several quality improvement projects focusing on patient experience and patient engagement.

People

The Trust recognises that the most important resource and greatest asset within the Trust is our staff. As we emerged from Covid to face new challenges, the trust has implemented a number of initiatives supporting our staff with the cost-of-living crisis and staying safe both physically and psychologically at work. The Trust has continued to develop staff networks supporting Black, Asian or other Ethnic Groups and improving the experience of other groups such as disabled, differently abled or LGBTQ+ staff.

Progress will continue as we deliver the new strategy 'Our People Together' developed during 2022 and was launched in May 2023 aiming to build on our strengths, fully develop the scope of working with our partners, and set out how Homerton Healthcare can best contribute to improving health and care over the next five years, in a changing society and a new NHS structure.

Our role in the wider health and care system

The Trust continues to review our position within the local care system as the new Integrated Care Boards mature. The Trust will develop further partnerships with local stakeholders and health care providers to deliver a model of integrated care and health. This work is supported by the Trust's quality priority program that includes improving our populations health, looking to support the health our local community before urgent intervention is required.

Alongside the excellent reputation for the quality of care we deliver, we are also proud to be known for our wider contribution to the health and wellbeing of the populations we serve. We work in a place, City and Hackney (C&H), that has strong identities and vibrant communities. We work in partnership with many public and voluntary organisations. Our Chief Executive, as well as being the leader of Homerton Healthcare, is place-based leader for C&H. This means that she has responsibility for bringing together people to build an integrated partnership of all health and social care providers, to improve the health and wellbeing of local people.

I remain extremely grateful to every member of our staff for their compassion and professionalism in delivering care across all our services and teams wherever these are delivered.

I hope that this Quality Account provides you with a clear picture of how important quality improvement, safety and service user and carer experience are to us at Homerton Healthcare NHS Foundation Trust. I'd like to end by saying a huge thank you to all our staff and local partners who have come together in such an exceptional way to serve our communities. I hope you find this account informative and see that our patients remain at the heart of everything our staff do.

Louise Ashley
Chief Executive

2.0 PART 2: PRIORITIES FOR IMPROVEMENT AND STATEMENTS OF ASSURANCE FROM THE BOARD

2.1 PRIORITIES FOR IMPROVEMENT

Following the completion of the consultation and approval process during 2022, 7 quality priorities were agreed by the Trust to be undertaken with an extended the improvement cycle of 2 years (2022 to 2024) to enable successful delivery of these workstreams and embed long term improvements. Table 1 below provides a summary of the current priorities with detail included throughout the report.

Table 1 below provides a summary of progress of each of the Trust's quality priorities, see section 3.1 of this report for a detailed overview of the progress made during 2022/23.

Domain	Priority No.	Priority Title	Achieved during 2022/23	Going forward 2023/24	Progress assessment
Safe	1	To reduce the number of community and hospital attributed pressure ulcers	✓ 'Time to Turn' initiative. ✓ Skin Ambassadors in place ✓ Community improvement projects	➢ Training for carers ➢ Training non-nurse workforce ➢ Embedding actions following investigations	
	2	Reducing physical violence and aggression towards patients and staff	✓ Body cameras for staff ✓ Upgraded CCTV cameras ✓ Community staff awareness & training	➢ Continue Maybe training ➢ Reduce physical assaults on staff ➢ Support for lone workers	
	3	Improved management and reduction in the rate of falls	✓ Flagging high risk patients; ' think yellow' ✓ Simulation training for post falls ✓ Hot debrief & after-action reviews	➢ Maintain 'think yellow' across Trust ➢ Launch E-learning package ➢ Share learning from QI projects	
Safe & Effective	4	Just Culture and Safe Environment	✓ Our Future Together Strategy ✓ Psychological 1st aid for staff ✓ Developing new patient safety incident reporting framework (PSIRF)	➢ Implementing PSIRF methodology ➢ Embedding reporting metrics ➢ Develop 'Just culture' framework	
Effective	5	Appropriate identification and management of deteriorating patients, including maternity, paediatrics and	✓ Established Deteriorating Patient Oversight Group ✓ Flagging patients at risk of deterioration	➢ Improve frequency and accuracy of NEWS scoring ➢ New CQUIN ➢ Support paediatric, maternity and	

		community-based services	✓ New system for recording the prescription oxygen	community work streams	
	6	Improving our populations health	✓ Our Future Together Strategy ✓ Developing smoking cessation service ✓ Neighbourhood projects for early language pathways, improving mental health and long-term health needs	➢ Develop health and wellbeing of children and families ➢ Embedded new mental health, learning disabilities and autism strategy ➢ Link to community screening programmes for diabetes and obesity	⏩
Patient Experience	7	Improving the first impression and experience of the Trust for all patients and visitors	✓ Our Future Together Strategy ✓ Patient engagement ✓ Our Estates plan	➢ Develop reporting metrics ➢ Collate other work streams	⏩

Table 1; Homerton Healthcare NHS foundation Trust Hospital Quality priorities for 2022 to 2024

Key to progress:

Positive progress – expected to deliver	⏫
Further development identified –	⏩

Further information on the progress of the quality priority programme can be found in part 3 of this report.

2.2 STATEMENTS OF ASSURANCE FROM THE BOARD

NHS foundation trusts are required by the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to include formal statements of assurances from the Board of Directors which are nationally requested to give information to the public. Therefore, the exact structure and content of these statements is structured as specified by the regulations that are common across all NHS Quality Accounts.

2.2.1 REVIEW OF SERVICES

During 2022/23 Homerton Healthcare NHS Foundation Trust provided and/or sub-contracted 68 relevant health services.

The trust has reviewed all the data available to them on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health services by Homerton for 2022/23.

2.2.2 NATIONAL AND LOCAL CLINICAL AUDIT

National clinical audits are primarily funded by the Department of Health and commissioned by the Healthcare Quality Improvement Partnership (HQIP) which manages the National Clinical Audit and Patients Outcome Programme (NCAPOP). Although National Clinical Audits are not mandatory, organisations are strongly encouraged to participate in those that relate to the services they deliver. It is mandatory to publish participation in National Clinical Audits in a Trust's Quality Account. A high level of participation provides a level of assurance that quality is taken seriously, and that participation is a requirement for clinical teams and individual clinicians as a means of monitoring and improving their practice. Local Clinical Audit is also important in measuring and benchmarking clinical practice against agreed standards of good professional practice.

The Trust participates in relevant national audits and confidential enquiries programmes as listed through HQIP. HHFT confirmed participation in 64 national clinical audits of the 70 applicable to the Trust and 4 of the eligible national confidential enquiries covered relevant health services that Homerton provide.

National clinical audits and confidential enquiries that Homerton participated in, and for which data collection was completed during 2022/2023 are listed in Appendix 1 alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Implementation of actions implemented following the publication of the national audit 2022/2023

The Trust views clinical audit as an important tool to measure the effectiveness of our services . and to improve the outcomes of our patients. Examples of actions that the Trust intends to take or has taken following the review of relevant national audit reports published during the financial year 2022/2023 are detailed in appendix 2.

It should be noted that due to a reporting lag the data referenced in national clinical audit reports could have been collated during previous financial reporting years.

Learning from local audits 2022/2023

Clinical audit is central to improving the quality and effectiveness of clinical care, to ensure that it is safe, evidence based and meets agreed standards. All staff are encouraged to complete clinical audits or other similar projects to monitor and improve services. There were 117 local audits registered during 2022/2023. The reports of 81 local clinical audits were reviewed during 2022/2023.

A selection of these audits is outlined in appendix 3 along with actions to improve the quality of health care provided.

2.2.3 PARTICIPATION IN CLINICAL RESEARCH

Clinical research remains high on the Government agenda with continued funding to Clinical Research Networks (CRN) ring-fenced for the promotion of research within the NHS. Research is written into the NHS Constitution, and this has recently been reinforced through the CQC inspection process. In September 2018 the Care Quality Commission (CQC) signed off the incorporation of clinical research into its Well Led Framework (NHS Trusts)[1]. The CQC formally recognises clinical research activity in the NHS as a key component of best patient care. Thus, clinical research is no longer perceived as just a 'nice to do' exercise in the NHS - it is now a key part of improving patient care. Furthermore, the government reflects this consensus through the continued funding of the National Institute of Healthcare (NIHR). Dame Sally Davies, Chief Medical Officer for England until September 2019, stated that 'Research is central to the NHS…. We need evidence from research to deliver better care. Much of the care that we deliver at the moment is based on uncertainties of experience but not on evidence. We can only correct that with research.' [2] This remains particularly pertinent in light of today's pandemic and the health crisis the population is encountering.

Homerton is committed to this path growing research capacity year on year. Innovation is a key focus in the coming years.

Our vision remains to ensure that research and innovation is an integral part of the functioning of the Trust, working with staff and patients to improve the health of our community. We aim to ensure that staff, patients and families understand the importance of research and that it is seen as a benefit and not a compromise to NHS clinical activity. We value those involved in research by offering support and training.

The number of patients receiving relevant health services provided or sub-contracted by the Trust in 2022/23 that were recruited during that period to participate in research approved by a research ethics committee was 1026.

We aim to open studies that are particularly relevant to the patients who are treated and cared for at Homerton Hospital and the wider population. We confirm with potential Principal Investigators that studies are in line with local clinical practice. During the lifecycle of each study the Research & Innovation (R&I) team ensure that all governance and regulatory processes are approved and adhered to; recruit patients who are eligible for the trial; collect and maintain necessary data and accurately record the data; and finally confirm secure archiving of all necessary trial related documentation at the end of the study. Additional approvals were sought during this pandemic from the Clinical Reference Group RG to ensure a balance between gathering vital information and ensuring our patients continued to receive optimal clinical care.

Participation in research remains important to patients with over 94% of a national consumer poll indicating that it is important for the NHS to carry out clinical research, with a similar number saying it was important so that new treatments could be offered by healthcare professionals. This figure was reflected in a small survey carried out locally by the research team.

The R&I team continue to be engaged in several high-profile studies that reflect our population. These include: *An Open Label Extension Study of GBT440 Administered Orally to Patients with Sickle Cell Disease Who Have Participated in GBT440 Clinical Trials,* sickle cell affecting disproportionately affects those of African and Caribbean heritage. We also contributed to *A Phase IIIb randomized open label study of nirsevimab (versus no intervention) in preventing hospitalizations due to respiratory syncytial virus in infants (HARMONIE)* a paediatric vaccine study.

The R&I team have been successful in supporting VERBO a Speech and Language Therapy (SaLT) innovation project which is now marketing to educational customers.

Financial challenges of 2021/22 have been overcome with an increase in commercial income and additional grant funding. It is expected this upturn will continue into the next financial years.

In 2022/23 R&I have encountered two major challenges this year. The first involved the research -80 freezers and centrifuges, which have not been housed in a suitable location since the downsizing of the in-house laboratory facility, it is anticipated this will be resolved in the coming months. The second challenge related to space for staff, but as 2022/3 concluded this saw a satisfactory resolution.

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1. Well Led Research in NHS Trusts: A Briefing for Clinical Research Network Staff about outputs from the work to establish research markers in CQC inspection
2. Excerpt from video Enhancing patient care through research

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2.2.4 GOALS AGREED WITH COMMISSIONERS

A proportion of Homerton Healthcare NHS Foundation Trust's income in the 2022/23 financial year was conditional on achieving quality improvement and innovation goals agreed between Homerton Healthcare NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for the 2022/23 and 2023/24 financial year and for the following 12-month period are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-23-24/

2.2.5 WHAT OTHERS SAY ABOUT THE HOMERTON

Care Quality Commission (CQC)

Homerton Healthcare NHS Foundation Trust is required to register with the Care Quality Commission. Its current registration status is 'registered with the CQC' with one condition attached to the registration. Homerton Healthcare NHS Foundation Trust has the following conditions on registration.

"The registered provider must only accommodate a maximum of 43 service users at Mary Seacole Nursing Home."

This is a reduction of 7 beds in comparison to the conditions on registration for the Mary Seacole Nursing Home in previous years. The reduction in bed numbers is administrative, and there is no actual bed loss to either the nursing home or the Homerton Transitional Neurological Rehabilitation Unit (HTNRU), where the 7 beds are located. The HTNRU is a wing within the Mary Seacole Nursing Home Building, however it operates independently of the home. For this reason, it is no longer considered within the Nursing Home registration.

There are no conditions of registration attached to the Homerton Hospital site or community services.

The Care Quality Commission has not taken any enforcement actions against Homerton Healthcare NHS Foundation Trust during the reporting period 2022/23.

We did not participate in any special reviews or investigation carried out by the CQC during 2022/23.

The Homerton Hospital site was last inspected by the CQC in January 2020, covering three core services: older people's services in medical care, maternity services and end of life care. The CQC considered the current ratings of the other services that were not inspected at the time and aggregated these with the services they did inspect, which resulted in the acute hospital site achieving an overall rating of 'Outstanding'.

The overall rating for the Trust remained 'Good', with the rating for both the Homerton Hospital and Mary Seacole sites unchanged in 2022/23. The following pages outline the current CQC hospital rating against the five domains of safe, effective, caring, responsive and well-led.

REPORT CONITUES ON NEXT PAGE

Homerton Healthcare NHS Foundation Trust:

Overall rating for this trust	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good
Are resources used productively?	Good
Combined quality and resource rating	Good

Homerton Hospital:

Overall rating for this hospital	Outstanding ☆
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Outstanding ☆
Are services well-led?	Outstanding ☆

Mary Seacole Nursing Home:

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Homerton Community Services

Action plans have been developed to address the CQC's recommendations, which are monitored and supported by Divisional and Trust-wide committees. Positive progress is being made against the plan, and a new IT solution to remedy the Maternity information software interface concerns is expected to go live in summer 2023. This will improve both safety and quality of care of Maternity services by ensuring that information is accessibly and securely held. Improvements made in response to the remaining actions are supported through the governance arrangements detailed elsewhere in this report, monthly audits using the 'Tendable' app and access to enhanced support from the Trust's dedicated quality improvement team.

2.2.6 NHS NUMBER AND GMC PRACTICE CODE VALIDITY

The patient NHS number is the key identifier for patient records. Accurate recording of the patient's General Medical Practice Code (Patient Registration) is essential to enable the transfer of clinical information about the patient from a Trust to the patient's General Practitioner (GP).

The Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data for **April 22 – Feb 23**:

- which included the patient's valid NHS number:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.30%	98.80%	99.60%		
Outpatients	99.70%	99.70%	99.70%		

- which included the patient's valid General Medical Practice Code:

SUS Dataset	Trust	London	National	Performance against London	Performance against National
Admitted Patient Care	99.80%	99.30%	99.80%		
Outpatients	99.60%	99.70%	99.50%		

- Emergency Care Data Set valid NHS number published in the Data Quality Maturity

Index for Reporting period November 22

SUS Dataset	Trust	National	Performance against National
NHS number	98.00%	81.90%	
General Medical Practice Code	93.80%	88.40%	

The Trust continues to focus on this area to ensure that high quality information is available to support the delivery of safe, effective, and efficient clinical services and support accurate and complete data submissions.

The Acute and Community Services Data Quality Committee's take place bimonthly. Locally agreed core DQ Acute and Community indicators continue to be monitored and discussed during committee meetings. This includes the Trust's NHS number and GP completeness as well as other data sets which are submitted to SUS.

Figures from the Data Quality Maturity Index (a monthly publication intended to raise the profile and significance of data quality in the NHS) are presented to the committees and the Trust's data quality performance is discussed. The DQMI mainly focuses on the completeness and validity of the data the Trust submits.

The Data Quality department complete quarterly audits to check the consistency of the key SUS data items for admitted patients and outpatients between SUS submitted data, Data warehouse tables and the front end of EPR (Cerner Patient Administration System).

The Data Quality Department distribute numerous DQ reports to services to improve the data completeness on clinical systems. There are on-going DQ checks, updates and staff training as and when new errors come to light.

Services contact the Data Quality team if they come across duplicate or confused records on the Trust clinical systems. This is investigated by the team who will then liaise with Healthcare records to merge. Where the query pertains to a duplicate or confused NHS number the query is reported to the National Back Office for investigation. Once there is a response and resolution the clinical system is updated. Duplicates and confusions are also picked up in the review queue of the MPI operator for HIE.

In addition, the DQ team work on several DQ clean up reports to improve the Trust's NHS number and GP completeness. This includes;

- the ***mini spine dashboard***, which flags records that have failed batch tracing due to NHS number, GP or address discrepancies. The team search for the correct demographics using the Summary Care Record and update the data on EPR.
- ***Keystone*** - which highlights correspondence that has No registered GP or unknown GP. The team search for the GP and send out the letter where the GP is found via hybrid mail.
- ***Current inpatients without NHS number or GP***
  Future outpatient appointments with no NHS number or GP
  Last week's AE Attendance with no NHS number and GP
  the team search for the NHS number and GP using the Summary Care Record and update EPR.
- ***GP association*** – the team clean EPR records where a GP has not been associated with a

practice
- ***GP clean up*** – the team update records where a GP has left the practice, or a GP practice has closed (data obtained from Organisation Data Service)
- ***RIO records without NHS numbers*** – the team investigate where there is a record with no NHS number. This is mainly the result of records being recorded locally and not linked to the spine. Where a national record is found the team will merge the local record.

2.2.7 INFORMATION GOVERNANCE ASSESSMENT REPORT

The Data Security and Protection Toolkit (DSPT) publish date has been deferred to June 30th 2023 by NHSE, due to Covid legacy impact. The status of the HHFT DSPT publication is designated as 'Approaching Standards' as assigned 1st July 2022 by NHSE.

2.2.8 CLINICAL CODING

Homerton Healthcare NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2022/23 by the National Audit Office.
Homerton Healthcare NHS Foundation Trust will be taking the following actions to improve data quality:

- On-going internal audit of clinical coding standards led by the Trust's Clinical Coding Auditor to identify areas where coding is not in line with national guidance
- Independent external audit of clinical coding standards to assess the overall quality of the Trust's clinical coding and to ensure any actions/recommendations are implemented appropriately (see attached the most recent report)

2.2.9 ACTIONS TO IMPROVE DATA QUALITY

The six dimensions of Data Quality (DQ); Completeness, consistency, accuracy, timeliness, uniqueness and validity are monitored on regular basis in order to provide intelligence for clinical and strategic decision making. The Trust strives to ensure that high quality information is available to support the delivery of safe, effective and efficient clinical services and support accurate and complete data submissions.

The Trust continues to have a monthly Data Quality Committee which reports to the Informatics Committee chaired by the Chief Executive. The committee alternates between Acute and Community services where both local and national indicators are reviewed and the steps the Trust needs to make to improve are discussed. Through the use of data quality indicators for both acute and community services, the committee is a vehicle for data quality improvement and awareness within the Trust. The committee promotes and maintains robust processes for creating and managing accurate information within the organisation and ensuring that information that leaves the organisation is of the highest quality. New data quality indicators will be monitored as and when identified and deemed necessary by the committees. This will continue to be the platform through which strategies, policies and standards are monitored to ensure they align with operational requirements.

A monthly Data Quality Bulletin is presented to the Informatics Committee by the Head of Information Services that highlights the Trusts position for both internal and national DQ indicators.

Regular daily, weekly and monthly processes are in place to monitor key areas such as;

- the accurate recording of patient demographics
- checking out and outcoming of appointments
- the timely production of discharge summaries and validation of notes
- accurate recording of length of stay (including A&E)
- the correct recording and coding of clinical events
- Caseload accuracy by monitoring the number of open referrals
- SUS data quality improvement
- DQMI data set improvement
- Death status on the Trusts clinical systems
- Mortality Data Flow Review

The Data Quality Team continue to work on updating the ethnicity of patients on the Trust's clinical systems using GP discovery data. The Trust has seen an improvement in outpatient ethnicity completeness from 94.2% in April 2022 to 95.8 % in Feb 2023. (Data from Commissioning Data Sets (CDS) Data Quality (DQ) dashboard 13/04/2023).

Similarly, there has been an improvement in the ethnicity and language completeness on the Community Services Data Set as seen below (Data from Data Quality Maturity Index (DQMI) as of 13/04/23).

Data Item	Nov-21	Nov-22
Ethnic Category	82%	90%
Language code	27%	51%

The DQ department has an internal SUS DQ dashboard that aims to capture admissions and attendances with data quality issues before the data is submitted to SUS. There has been a particular focus on the clean-up of main speciality, and there has been an improvement in completeness since this work was started in October 2022. The Trusts outpatient main speciality completeness has risen from 98.5 % in Sep 2022 to 99.3 % in Feb 2023 (Figures from CDS DQ dashboard 13/04/2023).

The team continue to monitor and manage the data quality on the master patient index of the Health Information Exchange. This is a critical piece of work ensuring that the Trust holds one record for every patient which can be viewed by other Trusts and organisations to ensure safe and effective clinical care.

There has been in improvement in the Trust's compliance with the Mortality Data Review Data Provision Notice. This mandates that all Acute trusts should update date of death on Spine services within 24 hours of the deaths which occurred in hospital (either in ward, theatre, A&E or outpatients) In September 2022 the Trust achieved 100% compliance after being at 30% in June. The Date Quality team continue to ensure the deaths are updated on the spine on a daily basis.

Quarterly audits are carried out in line with Data Security and Protection Toolkit guidance to ensure the validity and completeness of data submitted to Secondary Uses Service.

- Homerton Healthcare NHS Foundation Trust will be taking the following additional actions to improve data quality:

- The Data Quality Team will continue to maintain the Data Quality on the Health Information Exchange to ensure the information viewed by other Trusts is accurate and

complete.

- Continue to improve completeness in the Data Quality Maturity Index and Secondary Uses Service Dashboards by incorporating low performing completeness datasets into our Data Quality dashboards. By reviewing these data sets in the Date Quality committees we are developing a dialogue to push improvement forward.

- The Data Quality Team will be reviewing registration and check-in processes with services to ensure demographics are accurate. There will be a particular focus on ensuring GPs are associated with practices and that demographics are being checked at first point of contact at the hospital.

- Set up of a Data Quality intranet page.

2.2.10 LEARNING FROM DEATHS

During 2022/23 502 of the Homerton Healthcare NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

Reporting quarter 2019/20	Number of deaths	Number of completed reviews
Quarter 1	107	106
Quarter 2	128	128
Quarter 3	133	133
Quarter 4	134	97

Table 2: mortality reviews completed per quarter – work for Quarter 4 is ongoing

Part of the mortality review process includes assigning a likelihood that there were issues in the level of care that may have affected the outcome. These scores are allocated using the CESDI (Confidential Enquiry into Stillbirth and Deaths in Infancy) methodology which is defined as;

- CESDI 0 - No suboptimal care
- CESDI 1 - Suboptimal care, but different management would not have made a difference to the outcome
- CESDI 2 - Suboptimal Care – different care might have made a difference
- CESDI 3 - different care would reasonably be expected to have made a difference.

Following the reviews 4 patients (<1%) of the patient deaths during the reporting period) were judged to be more likely than not to have been due to problems in the care provided to the patient (CESDI 2).

At Homerton Healthcare, the CESDI score is agreed by the responsible Consultant and wider team and findings are documented on an electronic tool and shared through the governance process. The majority of all cases (as above) were additionally reviewed either in a multidisciplinary forum or by a second independent reviewer who was not involved in the care of the patient.

If a CESDI score 1 or above is obtained the case will be discussed in a multidisciplinary forum which includes identifying areas of good practice as well as opportunities for improvement. Themes are extracted and presented in the quarterly Board report and discussed in the Mortality Leads meetings and where appropriate actions are attached and completed.

To provide assurance of the review process, a minimum of 50% of reviews scored as CESDI 0s

are reviewed either in a wider multidisciplinary format or independently by a second reviewer. However, many teams choose to review all of their cases by in a multidisciplinary forum. Additionally, the majority of cases in 2022/23 were also scrutinized at the point of death certification in the bereavement office by one of six Medical Examiners.

All reviews scored as CESDI 2s and above are investigated via the Trust's Serious Incident review process (note there were no cases scored a CESDI 3).

Summary of learning from case record reviews over the period 2022/23:
Areas of good practice:

These are often noted on multiple occasions in the mortality review tool and include:

- Bipartite / tripartite decision making with other specialties.
- Consultant led updates for the family which were appreciated.
- Good recognition of severity of illness and family enabled to spend time with patient.
- Patient involved in decision making at end of life.
- NIV benefits were continued to be assessed and ceilings adjusted when the trajectory changed.
- Consideration given to capacity assessment where this was in doubt.
- Several reviews out of hours took place to ensure comfort.
- Consideration given to the preferred place of death.
- Simultaneous planning for several discharge options for a patient with unclear disease trajectory.
- Referral for an Independent Mental Capacity advocate made where there was no known NOK.
- Daily Registrar review over a weekend.
- Whole MDT involved in liaison with family which picked up concerns about discharge plans which were then reviewed and amended.
- Terminal agitation well managed with palliative care team input.
- Arranged for religious leader to meet with family.
- New terminal diagnosis communicated sensitively.
- Staff dealt with NOK distress in a sensitive manner.
- Family questions addressed post death by the Consultant during a long conversation.
- Effective hand over between wards on patient move.
- Family abroad kept updated.

Areas for improvement and actions taken:

- These are often a single incident. Action taken listed in brackets.
- Known to Community palliative care but when more unwell transferred to hospital despite wish to remain at home (Action: Discussed in Multidisciplinary mortality meeting with Palliative care team, discussion around when it is realistic for patients to stay at home at end of life and difficulties when no family able to facilitate this).
- No side room capacity for a patient at end of life (Action: discussion regarding the different priorities for a side room and the lack of side rooms for good end of life care at times).
- Pressure on ward nurse to move a patient whilst they were actively dying – in this case the patient did not move (Action: discussion in MDT meeting to support team to do what is right for the patient in the face of ward move pressures).
- A patient with advanced malignancy had no previous realistic discussion about prognosis and dying (Action: feedback to Oncology team as appropriate prompted by MDT).
- Family requested Coroner referral about the timing of observations (Action: Medical Examiner had a long discussion with family and made onwards Coroner referral

although no concerns raised from Medical Examiner scrutiny).

- Prescription of PRN anticipatory medications and difficulty in prescribing (Action: MDT discussion involving Palliative care team, highlighted in mortality newsletter).
- ITU step down out of hours (Action: this cannot always be avoided but importance of planning and hand over reiterated in joint meeting between ward and ITU).
- Challenging situation with family not accepting treatment escalation plan (Action: Discussed in Multidisciplinary mortality meeting with Palliative care team, discussion around what strategies can be helpful if family struggle to accept death).
- Urgent care plan not up to date pre admission despite advanced nature of underlying illness (Action: feedback where feasible with main outpatient specialty managing the long term condition).
- Anticipatory medication not prescribed (Action: discussed anticipatory prescribing in the specialty mortality meeting).
- Distressed family member assaulted a staff member (Action: Datix completed, appropriate involvement of senior staff to support the staff member).
- Learning disabilities practitioner not involved from admission (Action: Learning disabilities practitioner role now more embedded, has attended all wards and established links with specialties, recent Medical Unit Meeting, active case finding by LD practitioner).
- Difficult advance care planning discussion with a patient who did not wish to engage (Action: palliative care team has discussed in specialty mortality meeting what support can be provided by inpatient and community based teams).
- Sensory impairment not appreciated by all staff (Action: discussed simple ways of highlighting additional patient needs including during hand over time in the Specialty review meeting).
- Transferred from other hospital close to death (Action: feedback given to the neighboring Trust).

Summary of the key achievements during 2022/23:

<u>1. Review of deaths in patients within 30 days of admission who had stayed in A&E for 6 or more hours</u>

In response to a publication in the Emergency Medicine Journal in 2022 “Association between delays to patient admission from the emergency department and all-cause30-day mortality” the Trust undertook several pieces of work to review consecutive deaths for the period from July to September 2022. These did find that the majority of delays in admission from A&E were due to clinical rather than operational reasons and did not identify any clear cases of avoidable deaths. Reasons for and mechanisms of admission as well as presentation to A&E overall is a complex situation that can be influenced by many factors including outside factors and no firm conclusions can be drawn other that there is no clear evidence of delays of admission leading to avoidable deaths for the period reviewed.

<u>2. Review of deaths with health inequalities – special arrangements</u>

In addition to the now established processes of reviewing Learning disabilities deaths in liaison with the Lead Practitioner for Learning Disability and Autism and linking with the national “learning from lives and deaths : People with a Learning disability and autistic people (LeDeR) programme, and death with a mental health flag in liaison with the East London NHS Foundation Trust as appropriate, the quarterly report to the Quality Committee now also contains information on ethnicity.

<u>3. Strengthening of mortality reviews with Community facing teams</u>

The Integrated Independence team (IIT) has been involved in mortality reviews both within their team led by a Consultant Physician and joining the hospital specialty teams by discussing patients whose care has been spanning both the inpatient and community setting. This process is now further embedded and in addition the Medical Examiner team (which is a separate process) is now starting to review some community death after the Medical Examiner team was joined by three GPs.

4. Ongoing roll out of Structured Judgement Reviews (SJRs) and linking in with the LeDeR process

The Royal College of Physicians' structured judgement review (SJR) methodology is part of a whole range of measures intended for review of deaths for specific adult inpatients. It is a validated research methodology which blends traditional clinical judgement based review methods with a standard format. The benefit is that it provides a structured and replicable process to review deaths, which examines both interventions and holistic care. The aim is to look at strengths and weaknesses of the caring process, to obtain information about what can be learnt about systems where care goes well and identify gaps or problems in the care process.

The AHSN (Academic Health Science Network) "Implementing Structured Judgement Reviews for Improvement" based on The National Quality Board Guidance 2017 suggests that each Trust should have mechanisms to review deaths of people;

With a Learning Disability
With a Serious Mental Health Illness
Those aged under 18 years

A Standard Operating Procedure has been developed which recommends for completed structured judgement reviews to be reviewed in the 2 monthly Mortality Leads meeting and at this point fed back to the parent team and it is suggested that this is then included in the local mortality review process and that the electronic mortality tool is updated as appropriate. If an overall care score of poor or very poor care is reached then this is referred to the Trust Incident reviewing process. These cases are also fed into the departmental governance structure. In 2022/23 this process has been used to mainly review cases that are triggered by 1). but also if triggered by the Medical Examiner system and where there is uncertainty a second independent SJR reviewer is involved in this process. Outcomes were shared as appropriate with the Adult Safeguarding team and LeDeR reviewers. The national Learning from Lives and Deaths People with a Learning Disability and autistic people (LeDeR) programme is commissioned by the Health Quality Improved Partnership (HQIP) on behalf of NHS England. The overall aim of the programme is to support improvements in the quality of health and social care service delivery for people with learning disabilities and to help reduce health inequalities.

5.Publication of a mortality newsletter and dissemination of good practice and learnings

In 2022/23 work continued on the "Let's Talk about Death" mortality newsletter which is published on a 3 monthly basis on the Intranet and typically features learning cases and take home messages for a wide audience of Trust employees with the aim to provide ongoing examples for learning that span different specialties and enable better working for the benefit of patients with life limiting illness or those approaching the end of life. This is a joint enterprise by the Trust Mortality Lead and the End of Life Facilitator / Palliative care team and encourages others including trainees to get involved. In addition, work has been done highlighting some of the developments and achievements over the past years on the expanding mortality review process within the Trust.

2.2.11 SEVEN DAY SERVICES

Ten clinical standards for seven-day services in hospitals were developed in 2013. These standards define what seven-day services should achieve, no matter when or where patients are admitted. The focus was to ensure parity of care across the weekday and weekend.

Four of the 10 clinical standards were identified as priorities based on their potential to positively affect patient outcomes. These are:

- Standard 2 – Time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing review by consultant twice daily if high dependency patients, daily for others

The Trust continues to meet all these standards. This was last evaluated in July 2019 when the Trust repeated the case note review exercise reviewing 100 patients admitted to the hospital. The decision of whether a patient requires twice daily review or once daily was based on the clinical needs of the patient (using the standards set out in the national 7-day services guidance). Standard 2 (time to consultant review within 14 hours) was met in **87%** of patients. Considerable improvement was noted in those who received a review within that timeframe at the weekend (**96%**).

Clinical Standard 8 was met for patients admitted both during the week and weekend.

There has been no expectation from NHS England that further case reviews have been required since this time.

The on-call framework has not changed and consultant presence within the hospital continues to be prioritised both during the weekday and weekend. We continue to provide twice daily consultant reviews, when needed, as set out in standard 8. There is considerable flexibility built into the system so consultant cover can be increased to ensure these standards are met. An example of this was shown during winter 2021; consultant presence was increased with doubled up consultant rotas during covid surges. This was not required since this time but could be considered in the future If needed.

Future Plans – Seven Day Services

We will be guided by the national directives to determine what audits and notes reviews we undertake. We will continue to review incident reports and root cause analyses where there is any suggestion that there was a delay in consultant review. Winter planning will continue to be a priority to ensure these standards can still be met during periods of increased demand.

2.2.12 SPEAK UP SAFELY

Speaking up and ensuring a culture of staff speaking up is at the heart of the Trust's refreshed People Plan; 'Our Homerton People'.

The Trust has a Freedom to Speak Up: Raising Concerns at Work (Whistleblowing) Policy and Procedure in place which details how staff can raise concerns informally and formally as well as the feedback mechanisms required when concerns are raised. It also includes protections for staff raising concerns.

The Trust has one Freedom to Speak up Guardian in the Trust who has dedicated time to promote speaking up and support staff who speak up. Some of the ways this is being done are attending open days, Team meetings, providing workshops as part of the Band 6 development program and the International Nurses Recruitment program.

In quarter 3 of 2022 the Trust also recruited 5 Freedom to Speak Up Champions who are from the staff networks and based across the Trust. Their role is to emulate and promote Speaking Up as well as sign posting staff on how to raise concerns. In line with national regulations, the Trust has an executive lead (Director of People) and a named Non-Executive Director with responsibility for speaking up (Dr Michael Gill).

The Trust has a Freedom to Speak Up: Raising Concerns at Work (Whistleblowing) Policy and Procedure in place which details how staff can raise concerns informally and formally as well as the feedback mechanisms required when concerns are raised. It also includes protections for staff raising concerns. Additionally, the Trust is in the process of adopting the National Guardians updated Raising Concerns at Work Policy which will be in place by 2024.

In March 2023 the Trust created another route for staff to raise concerns this was by utilizing the incident reporting tool Datix. When reporting an incident staff can confidentially request further support from the Freedom to Speak Up Guardian. Datix was redesigned to allow staff to alert our FTSU Guardian, when they are concerned about an incident being reported. Only the Guardian will know this has done, and the Guardian can contact the member of staff to discuss the concern in complete confidence.

2.2.13 ROTA GAPS

Homerton has had a Guardian of Safe Working in place since the implementation of the new junior doctors' contract in 2016. Their role is to monitor the exception reports that come in and ensure any issues are addressed in a timely manner. Any vacancies in rotas are filled on a temporary basis by bank or agency doctors, whilst the post is advertised, and a substantive/fixed term doctor is appointed. The average fill rate for 2022/23 was 86% a decrease of 9% on the previous year.

Throughout the year there has been an upward variance in fill rate, with the quarters 1&2 having an average of 83% and quarters 3&4 average being 87%. There has been a continued attempt to use varied recruitment methods in some of the hard to fill specialties.

We still have some very hard to fill areas, with Radiology being a particularly difficult area with a national shortage of appropriately trained staff. The Trust Board of Directors receives reports from the Guardian of Safe Working on a quarterly and annual basis which includes details on fill rate and actions taken across the trust to support junior doctors.

2.3 REPORTING AGAINST CORE INDICATORS

All NHS foundation trusts are required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. Where the required data is made available by NHS Digital, a comparison has been made with the national average and the highest and lowest performing trusts. The data published is the most recent reporting period available on the NHS Digital website and may not reflect the Trust's current position (please note that the data period refers to the full financial year unless indicated). All data provided is governed by standard national definitions and the exact form of each of these statements is specified by the quality accounts regulations.

All Trusts are also required to include formal narrative outlining the reasons why the data is as described and any actions to improve.

1. Summary Hospital-level Mortality Indicator (SHMI) and patient deaths with palliative care; NHSI Quality indicator ref 12

The SHMI reports on mortality at trust level across the NHS in England. SHMI is the ratio between the number of patients that die following hospitalisation and the number of patients expected to die based on the national average and on the particular characteristics such as comorbidities of our patients.

It reports on all deaths of patients who were admitted to hospital and either died whilst in hospital or within 30 days of discharge. The Standardised Hospital Mortality Indicator is unaffected by palliative care coding.

SHMI has three bandings: higher than expected, as expected as and lower than expected. If the number of deaths falls outside the 'as expected' range, then the Trust will be considered to have either a higher or lower SHMI than expected. A 'higher than expected' SHMI should not automatically be viewed as bad performance, but rather should be viewed as a 'smoke alarm', which requires further investigation. Conversely, a 'lower than expected' SHMI does not necessarily indicate good performance.

If you would like to know more about how these ranges are calculated, then please refer to the NHS Digital website at: https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

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The data in table 9 below describes the SHMI has been sourced from NHS Digital. The data period is from Dec'21 to Nov'22. Our Trust SHMI score is 0.86 which equates to NHS Digital Band 3 (lower than expected deaths when compared to the national baseline). No data is yet available for the period from December 2022 to present. This compares to the SHMI for November 2020 – October 2021 which was 0.87 with Banding 3 so very little change from the previous year.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period	Dec 2021 – Nov 2022	Value:0.86 Banding: 3	Value: 0.999	Value:1.2219 Banding: 1	Value: 0.7173 Banding: 3
	Jan 2021 – Dec 2021	Value:0.86 Banding: 3	Value: 0.999	Value:1.1897 Banding: 1	Value: 0.7127 Banding: 3
	Jan 2020 – Dec 2020	Value:0.85 Banding: 3	Value: 1.0016	Value:1.1845 Banding: 1	Value: 0.7030 Banding: 3
	Jan 2019 – Dec 2019	Value:0.77 Banding: 3	Value: 1.004	Value:1.1999 Banding: 1	Value: 0.6889 Banding: 3
	Jan 2018 – Dec 2018	Value: 0.76 Banding: 3	Value: 1.00	Value: 1.23 Banding: 1	Value: 0.699 Banding: 3
	Oct 2017 – Sep 2018	Value: 0.69	Value: 1.00	Value: 1.27	Value: 0.69

		Banding: 3		Banding: 1	Banding: 3
(b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.	Dec 2021 - Nov 2022	39%	40%	13%	66%
	Nov 2020 – Oct 2021	45%	39%	11%	64%
	Jan 2020– Dec 2020	47%	37%	8%	61%
	Mar 2019 – Feb 2020	51%	37%	10%	59%
	Jan 2019 – Dec 2019	48%	36%	10%	60%
	Jan 2018 – Dec 2018	46%	34%	15%	60%
	Oct 2017 – Sep 2018	43.60%	33.80%	14.30%	59.50%

Table 3: SHMI scores since 2017 to 2022 (NHS Digital)

Assurance Statements

The data for SHMI has been sourced from HED, Trust benchmarking tool. The latest data period is November 2020 – October 2021. Our Trust SHMI score is 0.87 and banding is an NHS Digital Band 3 (lower than expected deaths when compared to national baseline) which is a trend which has continued from previous years.

How is the Trust doing?

- Our SHMI score remains below 100 and has been for the previous years. Care is however needed when interpreting the SHMI score in isolation. It is best viewed alongside other metrics.

2. Patient Reported Outcome Measures (PROMS) – NHSI Quality indicator ref 18

Patient Reported Outcome Measures (PROMS) is a questionnaire-based tool used to identify the quality and effectiveness of care delivered to NHS patients based on the patients' perception. All patients are asked to participate in the scheme which covers two clinical procedures:

- Hip replacements (primary and revisions)
- Knee replacements (primary and revisions)

A patient will complete two questionnaires: one prior to surgery and one six months after surgery. These questionnaires ask patients about their health and quality of life (as well as the effectiveness of the operation) before and after surgery.

Completion of these questionnaires is voluntary and the patient's consent to participate must be granted in order for the data to be used.

It should be noted that The completion of the development and assurance work by NHS Digital

required operational processes to be updated, this meant the linkage methodology took longer than expected which has caused a subsequent delay in the timeliness of the PROMS publication series. This delay meant that complete PROMs data was not available to the Trust at the time of completing the Quality Account report.

Indicator	Reporting Period	Homerton Performance	National Average	Lower 95% Confidence	Upper 95% Confidence
Total Hip Replacement Surgery	Apr 2021-Mar 2022	**No data available at the time of compiling quality account report**			
	Apr 2020-Mar 2021	**No data***	Insufficient cases to be included		
	Apr 2019-Mar 2020	0.482	0.453	0.382	0.523
	Apr 2018-Mar 2019	**0.546**	0.457	0.386	0.528
	Apr 2017 – Mar 2018	**0.478**	0.458	0.394	0.522
	Apr 2016 – Mar 2017	**0.467**	0.437	0.370	0.504
Total Knee Replacement Surgery	Apr 2021-Mar 2022	**No data available at the time of compiling quality account report**			
	Apr 2020-Mar 2021	**No data***	Insufficient cases to be included		
	Apr 2019-Mar 2020	**0.256**	0.334	0.268	0.400
	Apr 2018-Mar 2019	**0.339**	0.337	0.271	0.402
	Apr 2017 – Mar 2018	**0.332**	0.337	0.270	0.403
	Apr 2016 – Mar 2017	**0.334**	0.323	0.259	0.387

Table 4: PROMS data for hip, knee and hernia surgery.

Note: NHS England undertook a consultation on the national PROMs programme in 2016. As a result of the findings of that consultation, NHS England has now taken the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections.

Assurance statements

The Trust considers that this data is as described for the following reasons:

- Homerton Hospital has processes in place to ensure that relevant patient cohorts are provided with pre (Q1) and postoperative (Q2) questionnaires. Patients are asked to complete the Q1 form and post back to Homerton for submission rather than NHS Digital.

The Trust intends to take the following actions to sustain and improve the PROMS, and so the quality of its services.

- Q1 data collection recently restarted in 'joint school' face to face since July 2022

- Trust to consider local collection / analysis of PROMS on Amplitude data analytics platform rather than using paper forms.
- Reviewing PROMs data when available and discussing these within relevant departments.
- Reviewing PROMS data on a regular basis through the Improving Clinical Effectiveness Committee.

3. 28-day emergency readmission rate - NHSI Quality indicator ref 19

Every acute Trust submits their admitted patient activity to Secondary Uses Services (SUS) as per the mandated timetable. Every month the submitted SUS data is cleansed by HES (Hospital Episodes Statistics). This dataset is provided to authorised organisations like HED.

The readmissions data is based on PbR (Payment By Results) logic.

Indicator	Reporting Period	Homerton Performance
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 0-15	2022/23	5.44% (London Average 7.54%)
	2021/22	5.51% (London Average 7.56%)
	2020/21	4.94% (London Average 6.86%)
	2019/20	4.97%
	2018/19	4.36%
	2017/18	4.66%
	2016/17	3.63%
The percentage of patients readmitted to a hospital which forms part of the trust within 28 days of being discharged from hospital which forms part of the Trust during the reporting period: aged 16 or over	2022/23	8.40% (London Average 7.02%)
	2021/22	8.05% (London Average 7.56%)
	2020/21	9.23% (London Average 8.00%)
	2019/20	9.12%
	2018/19	12.60%
	2017/18	11.95%
	2016/17	12.70%

Table 5: 28-day readmission rates for patients aged 0 – 15 and aged 16 and over. Source is HED benchmarking tool.

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust uses the 30-day readmission standard rather than 28-day readmission.

The Trust has a robust clinical coding and data quality assurance process, and 30-day readmission data is monitored through the Trust Management Board on a monthly basis. The

Trust board readmission rates have agreed local exclusions applied over and above the PbR logic.

The Trust has the following to support regular monitoring and take actions as required

- Information team has developed an electronic readmissions report that enables local services to drill down seamlessly from Trust wide through divisional to local level and identify possible causes of the increased readmission rates.
- It has been agreed by the Trust's Improving Clinical Effectiveness Committee that utilisation of the readmission report will be overseen the Divisional Leadership teams will support the specialties in the real time review of outliers and identify urgent interventions to reduce readmission.

4. Responsiveness to personal needs of patients – NHSI Quality Indicator 20

The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.

Indicator	Reporting Period	Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The Trusts responsiveness to the personal needs of its patients during the reporting period.	2021/22	Not available	Not available	Not available	Not available
	2020/21	73.0	74.5	67.3	85.4
	2019/20	64.7	67.1	59.5	84.2
	2018/19	63.4	67.2	58.9	85.0
	2017/18	68.1	68.6	60.5	85.0
	2016/17	66.3	68.1	60.0	85.2

Table 6: responsiveness to personal needs – source NHS Digital; NHS Outcomes framework

Note: Following the merger of NHS Digital and NHS England on 1st February 2023, NHS Digital are reviewing the future presentation of the NHS Outcomes Framework indicators. As part of this review, the annual publication which was due to be released in March 2023 has been delayed and is not available at the time of publication.

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust uses an approved contractor, PICKER Institute to collect the required data which follows the methodology set out by the CQC.

With the increasing demands on our services and the recovery following the pandemic, we continue to report a high number of patient satisfactions. The Trust acknowledges that on occasions it may not be as responsive as it would like or expect to be, especially when the system is under extreme pressure.

Despite the challenges, the Trust's FFT data indicates high scores (April 2021-March 2022 = 90% [national benchmark = 85%]). The data shows a consistency in delivery and an upward curve over the past year in responding to the needs of our patients.

- The Trust is actively supporting staff with developing and completing quality improvement projects which will focus on patient experience and engagement to ensure that care provided

is tailored to individual needs.

- The Maternity department are currently developing new pathways for women to advocate for their wishes that include their cultural or religious needs in response to some patient feedback around discharge processes and patient wishes.

- In response to the Trust updating its values with the addition of “inclusive” we are now ensuring that patient stories are shared at every trust level board meeting, that patients can take part in service specific forums to give feedback and that they are able to co-chair our “Homerton Patient Voices” meetings to help steer the conversation to ensure it’s meaningful. This group also helps focus the Trust on patient feedback, their concerns and what really matters to them.

- The bereavement service is developing a new feedback tool to capture the experience of relatives and friends who have been impacted by the loss of a loved one at the Homerton. This is to ensure that throughout the whole patient journey we can ensure the patient and their loved ones are supported and included in the process.

- The introduction and development of the PIFU (Patient Initiated Follow Ups) pathway, patients can have a review period without an appointment and can initiate contact with the service to seek advice or bring forward an existing appointment, if their condition requires it. Patients are supported throughout the pathway with self-management tools, education and information on how to access the service as and when required

The National Staff Survey 2021 ran during October and November 2022 and was open to all staff employed substantively or under contract on 1 September 2022

The Trust’s 2022 results showed a reduction of 4% in recommendation as a place to receive care for their friends and family: down to 72%.

83% of our staff responding to the survey expressed the view that the care of patients/service users is the organisation's top priority.

Assurance statements
The Trust considers that this data is as described for the following reasons:

- The survey was conducted on behalf of the Trust by Picker Institute, an approved provider by NHS England. All full- and part-time staff employed by the organisation on 1 September 2022 (with certain specific exclusions) had the opportunity to complete the survey electronically between October and November 2022. The Trust achieved a return rate of 47% over 50.5%, which represented a decrease of 3.5% from 2021.
- The Trust’s 2022 results showed a reduction of 4% in recommendation as a place to receive care for their friends and family: down to 72%.

The Trust intends to take the following actions to sustain and improve the percentage of staff recommending the Trust to their friends and family, and so the quality of its services.

We will act on this information responsively to drive further improvements in engagement levels by:

- Continuing to implement ‘Our Homerton People’ plan - The plans and projects that will deliver the improvement in our people’s experience be made of the following key elements:

- People matter at Homerton Healthcare
- Achieving equality and inclusion for our people
- Creating a values-led organisation for all our people
- Supporting the health and wellbeing of our people
- Developing our people's potential
- Recruiting our People
- Developing our people's potential

5. Rate of admissions risk assessed for VTE - NHSI Quality Indicator 23

Venous Thromboembolism (VTE) is a significant cause of mortality, long-term disability, and chronic ill-health problems – many of which are avoidable. It is estimated that as many as half of all cases of VTE are associated with hospitalization for medical illness or surgery. VTE is an international patient safety issue and its prevention has been recognized as a clinical priority for the NHS in England**.**
Since the COVID 19 pandemic, the number of VTE risk assessments being performed within 24 hours has fallen below the target of 95%.

The reasons for this include:

1. Changes in the alert where a VTE risk assessment was not completed- previously these forced a decision before all the relevant information was available but in response to these concerns the alerts have been changed to regular reminder pop ups.
2. As activity has moved around the hospital there may be some issues with data quality- especially in surgical specialties where some patients not admitted to hospital may have been counted in totals –this continues to be an issue.
3. The effect of COVID 19 and then rises in urgent care demand – this is now less of an issue.

Our current figures for 2022/2023 are an improvement on the previous year.

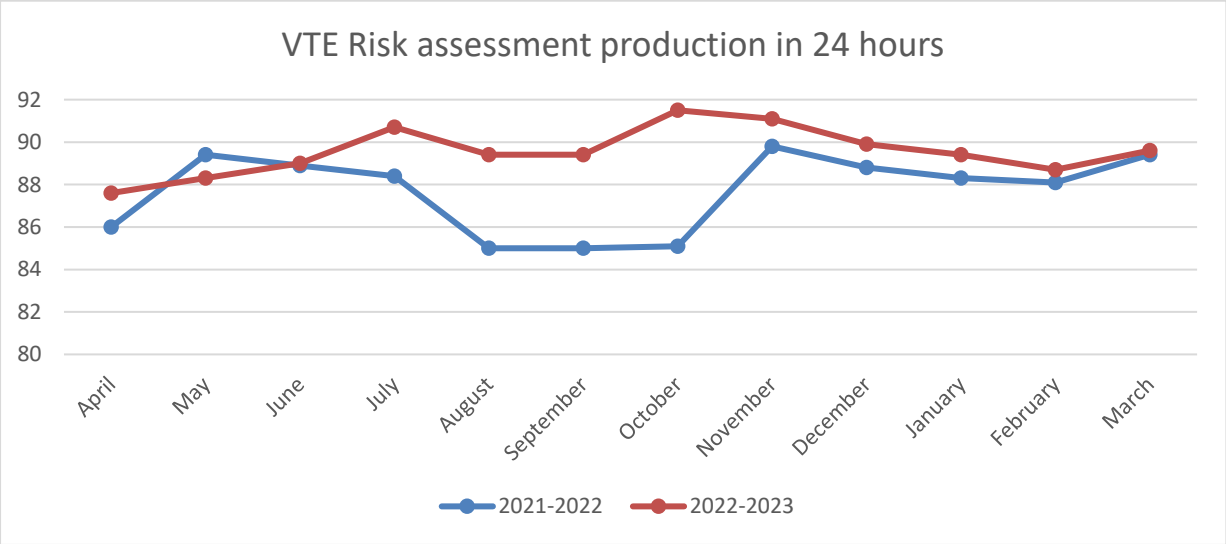


Figure 1: VTE risk assessment produced with 24 hours

Performance in 2022-2023 remained variable. The overall target of 95% completion was not reached. Overall performance was between 88 and 90% across the year.

Reporting Period		Homerton Performance
2022/23	Q1	**88.3**
	Q2	**90.3**
	Q3	**90.9**
	Q4	**89.2**

Table 7: Performance 2018-2022: ***(note national reporting was suspended since 19/20)***

Indicator	Reporting Period		Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2020/21	Q1	**88.9**	N/A	N/A	N/A
		Q2	**86.3**	N/A	N/A	N/A
		Q3	**85.7**	N/A	N/A	N/A
		Q4	**88.5**	N/A	N/A	N/A
	2019/20	Q1	**95.6**	95.6	69.8	100
		Q2	**95.9**	95.5	71.7	100
		Q3	**96.2**	95.3	71.6	100
		Q4	**93.6**	*	*	*
	2018/19	Q1	**95.5**	95.6	75.8	100
		Q2	**97**	95.5	68.7	100
		Q3	**96.9**	95.7	54.9	100
		Q4	**96.2**	95.7	74.3	100
	2017/18	Q1	**97**	95.2	51.8	100
		Q2	**96.7**	95.3	71.9	100
		Q3	**97.4**	95.4	76.1	100

Indicator	Reporting Period		Homerton Performance	National Average	Lowest Performing Trust	Highest Performing Trust
		Q4	**96.6**	95.2	67	100

*Table 8: VTE risk assessment data (NHS Digital); *publication suspended due to Covid*

Although there continues to be a significant difference in performance between the directorates there have also been many quality improvement innovations implemented to address the different aspects affecting performance in each division.

Assurance statements
There is clear plan to address the performance within the two clinical divisions.

Emergency Care, Medicine and rehabilitation services (EMRS)
For most of the year VTE performance across EMRS has been consistently greater than 90%. The 95% target was also met on several occasions.
There was an expected drop in performance in Quarter 4. This was related to high-volume winter activity, and significant increase in the number of medical admissions. During this period a significant number of patients were waiting in ED for greater than 4 hours. Patient records in ED are accessed via FirstNet. Firstnet does not have an automatic VTE pop up as most patients do not require VTE assessment as are not being admitted. This may explain a slight dip in completion of VTE forms.
VTE champions continue to help lead on VTE and check performance daily. This oversight has helped improve the EMRS completion rates over the last year.
It is also reassuring that when the small number of cases where the form has not been completed are reviewed the finding is that patients had appropriate VTE prophylaxis but that the form was not documented.

Surgical Women's and Neonatal Services (SWNS)

Most elective surgery patients arrive to the surgical admission areas on the day of surgery and are prepared for surgery by nurses and healthcare assistants. Completion of the VTE risk assessment form is the responsibility of the surgical team and is often completed by the most junior member of the team. Removal of the mandatory requirement in the electronic record for VTE risk assessment to be completed, has impacted completion rates in surgery more than medical patients.
Steps to improve VTE risk assessment compliance within SWNS has been to follow a Quality Improvement approach, initiating QI projects in several surgical specialties – the logic being that each of the specialties will be best placed to suggest improvements and engage with/implement solutions.

Quality improvement projects in T&O and general surgery have helped raise VTE assessment completion rates. The new surgical safety check has also been launched this financial year ensuring VTE risk assessment is discussed in the team brief prior to patients coming to theatre. Following this the maternity surgical safety checklist was also introduced in the latter part of 2022.

Where surgery is cancelled, cases continue to have incomplete VTE risk assessments – accounting for approximately 3% of VTE risk assessments reported. To address this a tick box has been added in EPR so that surgical patients admitted for a procedure that is then cancelled on the day, no longer require to have the full VTE risk assessment.

A nursing checklist on EPR has also been identified to which VTE risk assessment will soon be added as a point requiring to be checked off. This will be a final check before the patient leaves the department for discharge home or to the inpatient ward.

Reassuringly despite neither division achieving the 95% complication rate the overall VTE incidence in the hospital has not increased over the last few years

6. Clostridium difficile rate - NHSI Quality Indicator 24

Clostridium difficile infection (CDI) remains an unpleasant, and potentially severe or even fatal, infection. CDI occurs mainly in elderly and other vulnerable patient groups especially, but not solely, in those who have been exposed to antibiotic treatment.

The laboratory for the Trust processes stool samples for *C.difficile* testing from both inpatients and community (GP) patients and all *C.difficile* toxin positive results are reported to the UK Health Security Agency (UKHSA) .

Since 19/20 the definition of Trust-attributable cases have been:

- HOHA=Hospital Onset Hospital Acquired = cases detected in the hospital two or more days after admission
- COHA = Community Onset Healthcare Associated = cases occurring in community/within 2 days of admission when patient has been an inpatient in reporting Trust in previous 4 weeks
- COIA = Community Onset Indeterminate Association = cases occurring in community/within 2 days of admission when patient has been an inpatient in reporting Trust in previous 12 weeks but > most recent 4 weeks.
- COCA = Community Onset Community Associated = cases occurring in community/within 2 days of admission when patient not an inpatient in reporting Trust in previous 12 weeks.

With this definition all HOHA and COHA cases are defined as ‘trust-attributable’.

The threshold for 22/23 was 19 Trust-attributable cases. There were 16 Trust-attributable cases (13 HOHA and 3 COHA) in 22/23.

The latest UKHSA ‘Fingertips’ data for *C.difficile* infection counts and 12 month rolling rates of hospital onset-healthcare associated cases, by reporting trust and month runs up to Jan-23. The Homerton rate is 15.0 per 100,000 against a national average of 20.1 per 100,000 i.e. lower than the national average.

The Trust hospital-onset rates for the past 7 years are reported in the graph below:

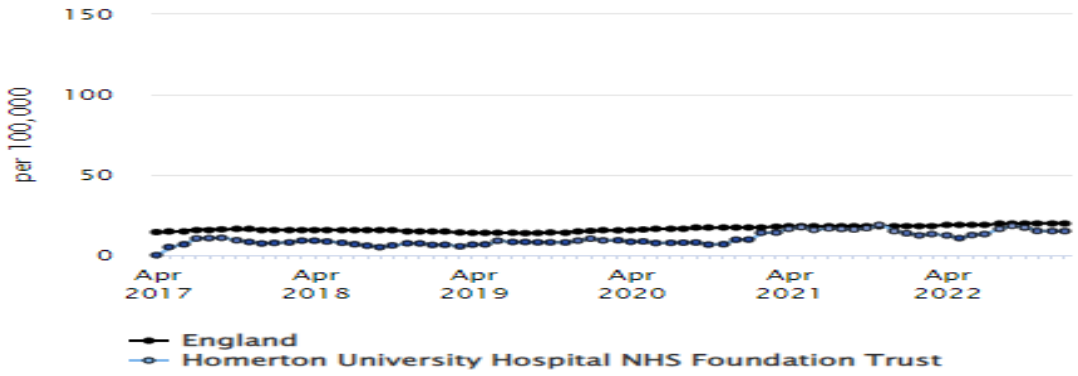


Figure 2: Homerton Healthcare c. diff rates

Assurance statements

The Trust considers that this data is as described for the following reasons:

The data for results up to Jan 23 has been taken from the UKHSA 'Fingertips' website (accessed on 02/05/23):

Public health profiles - OHID (phe.org.uk)

The unbenchmarked data for 22/23 is the data taken from the Trust's Winpath pathology IT system and submitted, after Chief Executive sign off, to the UKHSA surveillance website on a monthly basis. This data is cross-checked by the DIPC pre-sign off on a monthly basis by comparing a spreadsheet of the monthly Winpath laboratory data with the data submitted to the UKHSA website by the Infection Prevention & Control nurses.

All Trust-attributable *C.difficile* cases are reported as incidents and followed up by the ward team & Infection Prevention & Control team in partnership using a Post Infection Review (PIR) tool. The PIRs are then reviewed and signed off by the Trust's Assurance Panel.

The Trust continues to work hard at reducing the risk of *C-difficile* infection to our patients including continuously improving our already embedded processes for risk reduction by antimicrobial stewardship, prompt identification of possible cases and prompt laboratory testing processes.

The Trust intends to take the following actions to continue to decrease the rate of Trust-attributable *C-difficile* infection where there are lapses in care identified. However, it must be recognised that some cases of *C.difficile* infection are not preventable.

- *C.difficile* awareness teaching is included in the Infection Prevention & Control mandatory induction & annual update training.
- Focus on timely isolation of all ward patients with diarrhoea (where there is a possible infective cause) whilst awaiting *C.difficile* testing results.
- Focus on timely sending of diarrhoeal samples for testing for *C.difficile* enabling prompt identification of *C-difficile* toxin positive cases.

- Environmental decontamination by 'terminal' cleaning of the patient's bed space on side room transfer (if applicable) and after discharge from side room
- Focus on clutter reduction in ward environments to enable high standards of cleaning.
- Regular audits to ensure compliance with national and local guidelines.
- Daily antimicrobial stewardship reviews of antimicrobial prescribing.
- Root Cause Analysis using a Post Infection Review (PIR) investigation tool of every case to identify lessons to be learnt and feedback to the multidisciplinary teams and into the governance structure to ensure learning across the Trust.

7. Patient Safety Indicators – NHSI Quality Indicator 25

Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS in learning from mistakes and in taking action to keep patients safe. Patients should be treated in a safe environment and protected from avoidable harm.

Homerton actively encourages its staff to report all adverse incidents that have either caused harm or have the potential to cause harm during their care at the Trust. This is to ensure an open and transparent culture and promote organisational learning from safety incidents with the intention of preventing similar incidents from reoccurring in the future. Like NHS England, the Trust considers its high reporting culture as a 'positive indicator of its healthy safety culture, giving organisations the chance to learn and improve'.

During 2022/23, 13,689 incidents occurred across Homerton Healthcare, of which 11,151 were patient related. This is the highest number of incidents ever reported in a single financial year across the Trust, over 1,500 more than the previous year and represents an ongoing trend of increased incident reporting.

The table below shows the patient safety incidents that occurred in 2022/23 by harm caused. 72.8% of patient safety incidents caused no harm to patients.

Actual harm reported	Number	Percentage	National average (from 2021/22)
No harm	8116	72.8%	70.6%
Low harm	2631	23.5%	26%
Moderate harm	330	3%	2.9%
Severe harm	19	0.2%	0.3%
Death (safety incident related)	0	0%	
Death (not safety incident related)	55	0.5%	0.2%*
TOTAL	**11151**	**100%**	**100%**

Table 9: Number of patient safety incidents reported by harm caused.

please note in national figures there is only one category for incidents resulting in death which does not distinguish between deaths related and not related to safety incidents.

Assurance statements

The Trust considers that this data is as described for the following reasons:

The Trust submits all eligible incidents to the National Reporting and Learning System. Benchmarking data is no longer published by NHS England, but there is a year on year increase in incidents reported across the Trust, providing assurance that we remain a high reporting organisation. We report a higher than average number of incidents causing no harm and a lower than national average percentage of incidents causing harm.

During 2022/23 the Trust continued to work with staff to ensure incidents were appropriately reported, investigated and actions taken where necessary to improve patient safety. Improvements have been made to how lessons learned from investigations are shared across the organisation, and during the year, a new monthly Spotlight on Learning newsletter was launched. The Patient Safety Team provides a range of training across the organisation, via trust and junior doctor induction, ward development days, the nurse preceptorship scheme and many other forums to ensure staff feel supported in reporting incidents, and receive feedback on actions taken and lessons learned.

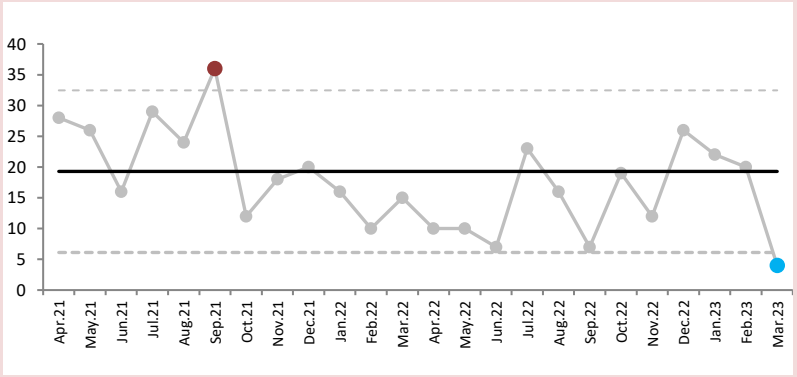
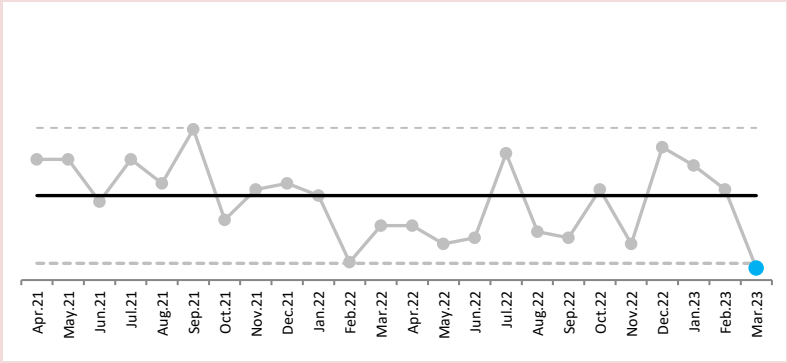
In August 2022, the new Patient Safety Incident Response Framework was published, and the Trust has undertaken a significant amount of work since then to ensure the organisation is ready to implement it in the autumn of 2023. This has included establishing an implementation group, chaired by the Chief Nurse; a detailed analysis of our incident profile in preparation for the development of the Patient Safety Incident Response Plan and Policy, and engagement with teams across the organisation to ensure they are aware and ready for the changes. The Trust welcomes the new Framework, and is excited by the potential for learning and improvement that it presents.

Further improvement work to the Datix Incident Reporting system has taken place throughout the year, and this will continue into 2023/24 as the system is updated ahead of the introduction of the Learning from Patient Safety Events (LFPSE) service, which will replace NRLS and STEIS for national incident reporting in the autumn of 2023.

3.0 Part 3: Other information

3.1 Overview of the progress with the Trust's 2022 to 2024 quality priorities

The following section describes the progress of each quality priority, the actions taken to drive the priorities, reporting metrics and the key risks identified going forward;

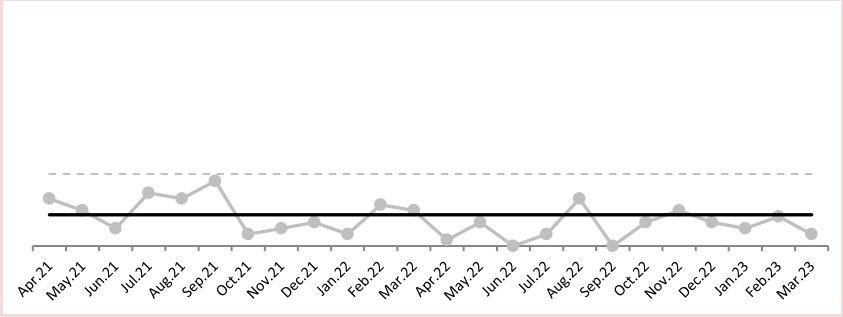
Priority Title Domain	Target/Goal	Commentary	Reporting metrics *(where available)*
1. To reduce the number of community and hospital attributed pressure ulcers **Domain:** **SAFE**	➢ To reduce number of hospital-acquired Category 3 and above PU with lapses in care by 60% ➢ To reduce number of community-acquired Category 3 and above PUs with lapses in care by 40%	**Progress made during 2022/23** ➢ Pressure Ulcer Strategy Group has encouraged a systemic approach to identify the challenges, find solutions, and drive change over the past months ➢ Trust strategy approach launched May 2022 supported by the Quality Improvement and Tissue Viability Team. ➢ Developed a Time to Turn Communications plan and commenced implementation ➢ Skin ambassadors programme started in May 2022 devised Community Pressure Ulcer Action Card that supports use of the ASSKING bundle ➢ Time to Turn Conference held in November during Stop the Pressure awareness week. ➢ Introduced Skin rounding trial on ECU north and patient turning added to documentation on RNRU ➢ Reviewing the nursing detail assessments and care plans on EPR ➢ Mini QI project launched in the community ➢ Training programmes for reviewed and now includes staff development days, preceptorship training for newly qualified nurses and overseas nurses joining the Trust and the Essential Skills Programme for healthcare assistants ➢ Pressure Ulcer Scrutiny Committee will continue to meet monthly to review incidents and lapses in care. The learning points and actions are summarised feedback to Leads and teams via email.	➢ Total number of pressure ulcers record as lapses in care.  ➢ Reduction in the number of hospital acquired pressure ulcers reported during 2022/23 

- Current hospital mattress pathway has been updated and capital funding has been approved for gradual replacement of the older dynamic mattresses
- Bed contract for the acute site and Mary Seacole Nursing Home (MSNH) has been reviewed to look at the available mattress options, and the ordering/ cancelling process to ensure there is enough equipment onsite
- Skin Ambassador Role was introduced with 11 community staff and 28 acute staff, either Health Care Assistant or Registered Nurse put forward for the role
- Achieved compliance with CQUIN 12 - Achieving 85% of acute and community hospital inpatients aged 18+ having a pressure ulcer risk assessment that meets NICE guidance with evidence of actions against all identified risks.
- The Datix form has been changed with the aim of making reporting easier and enable collection of more accurate date leading to simplified analysis to truly understand how we are doing regarding pressure ulcer prevention and management.

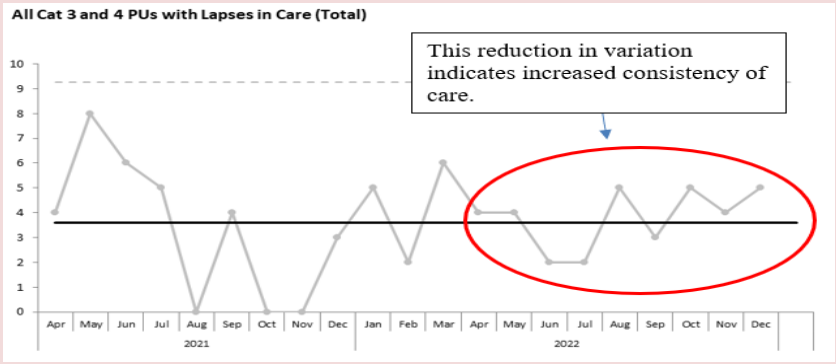
Key steps going forward into 2023/24

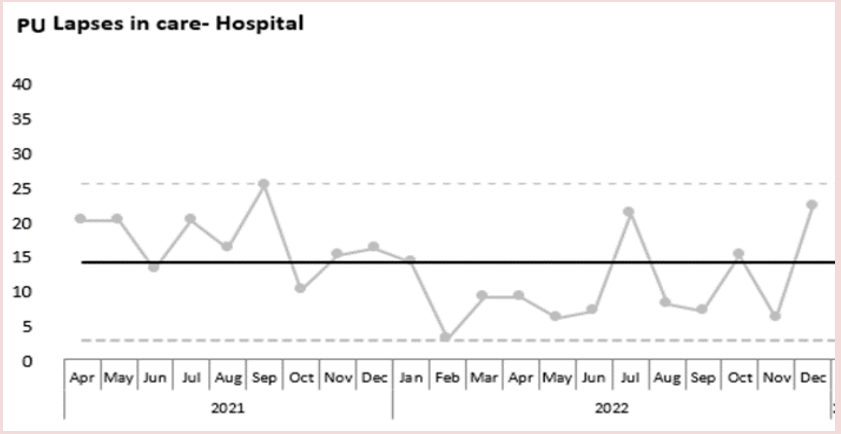
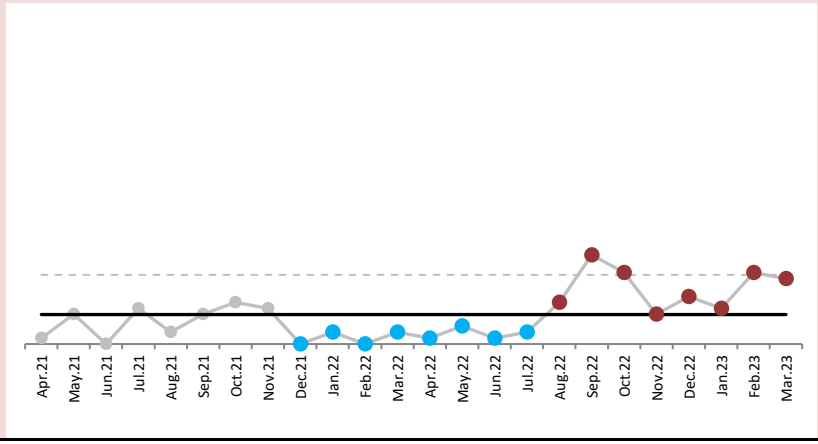
- Identify education and training needs of formal carers and ensure that the information provided meets their needs.
- Research digital options to support the programme to improve patient care and preventative approaches.
- Increase service user involvement in the programme.
- identify education and training needs of the non-nursing workforce (AHPs and others) within the Trust.

- Reduction in the average number (thick line) of Pressure ulcers with lapses in care across the acute and community

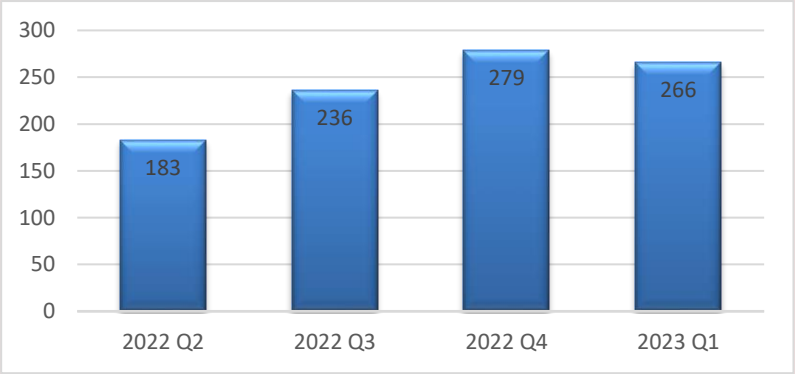


- The variation in numbers of pressure ulcers graded as category 3 or 4 with lapses in care has reduced, this indicates a greater consistency of care.

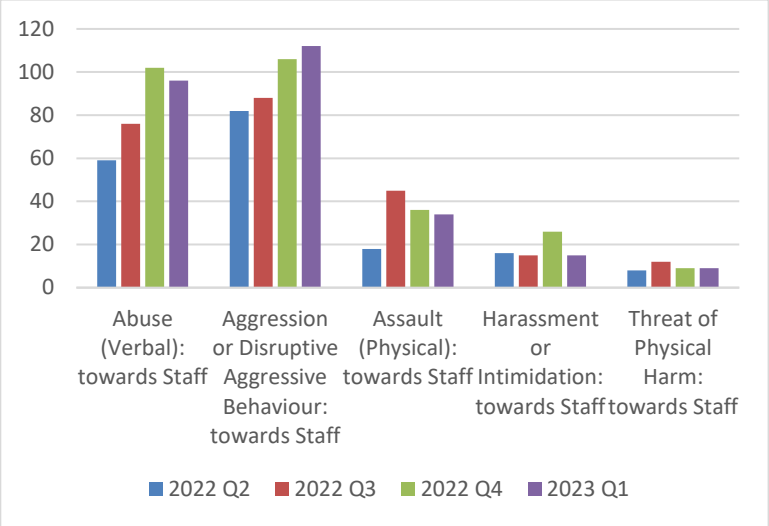


		➢ Request a review of PU related community equipment with the Local Authority who are the commissioners for this service. ➢ Ensuring that actions identified in PUSC and mini–Root Cause Analysis are completed and embedded. ➢ Understand what needs to be done to address the human factors identified in incidents and SIs. ➢ Identify continuous areas for improvement through the PU Strategy Group, skin ambassadors, staff and patients. ➢ Continue engaging with TVS colleagues from other areas to share learning, ideas, and resources. ➢ Summer 'Time to Turn' Symposium to review progress made during 2022/23 including presentations of the Skin Ambassador change ideas and their findings. ➢ Design a designated pressure ulcer page on the intranet for staff and website for the general public. ➢ Utilising new incident reporting structure on Datix to enable Statistical Process Control Charts (SPC) and detailed data by ward and neighbourhood teams. ➢ Increased collaborative work between Children's Community Nursing team and Children's Therapies team to review the PU prevention pathway and wound care management has been reviewed and adapted. ➢ Online educational resources developed by the National Wound Strategy and industry partners available for staff wound care competencies through self-guided study. ➢ Scope local improvement projects identified by Skin Ambassadors introduced with 11 community staff	➢ The numbers of all categories pressure ulcers with lapses in care have remained consistent on the acute site  ➢ The number of all categories of pressure ulcers with lapses in care have remained consistent within community settings 

		and 28 acute staff on both community and acute settings.	

2. Reducing physical violence and aggression towards patients and staff. **Domain:** **SAFE**	➢ To make staff feel safe and secure giving them confidence and skills to deal with various forms of violence and aggression enabling them to deliver the best level of care to patients. ➢ Increase the use of lone worker devices ➢ Increase the number of staff receiving Maybo training	**Progress made during 2022/23** ➢ Body worn cameras for ED front line clinical & reception staff. ➢ Monthly V&A review meeting set up with Met Police and ED senior staff, review body cam footage and assist with ongoing investigation. ➢ Community Personal Safety Awareness Sessions with Met Police for all our community staff, 1st session was in January 2023 a further session booked for February; to inform and give advice to staff of potential risks while working in the community and how to keep themselves safe). ➢ Upgraded Trust wide CCTV cameras to IP HD cameras to support with prosecution ➢ Maybo enhanced CRT included on Trust induction, additional training sessions added from October 2022 to ensure 4 sessions a month. ➢ Updated intranet pages with information and videos staff safety initiatives. ➢ New V&A posters circulated and displayed in departments/wards. ➢ Community lone working staff receiving additional training on lone worker device usage to improve personal safety. ➢ Quarterly violence and aggression committee ongoing.	➢ Regular incidence of 'violence/aggression' and 'assaults on staff'  ➢ V&A incidents reported by category

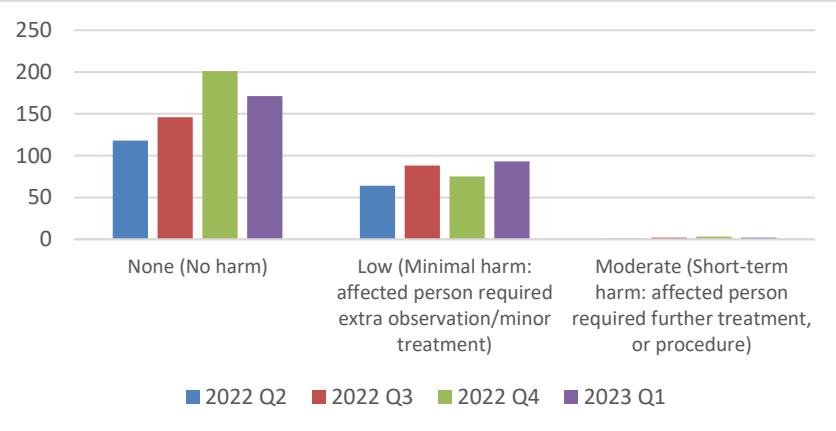
- Introduced a new sanction card in the V&A policy, Orange card for the community which is an injunction from specific community services.
- Since April 2022 22 yellow cards, 4 red cards, 1 orange card have been issued to clients.
- Continued partnership with Met Police on Operation Cavell, 4 police community protection notice issued (CPW).
- Increased number of reported crimes to police showing staff are more confident in escalating incidents with police. Increased number of convictions and fines resulting from offenders being arrested by the police for V&A incidents.



Key steps going forward into 2023/24

- Reduction of physical assaults on staff
- Continue raising awareness and improve reporting of incidents on Datix and to the police if appropriate.
- Impowering staff to not tolerate violence and aggression and seek sanctions through hospital process and police.
- Continue providing training in Maybo.
- Continue lone worker device to support staff in the community and acute site.
- Community Personal Safety Awareness Sessions with Met Police for all our community staff, 1st session was in January 2023 a further session booked for later in the year - to inform and give advice to staff of potential risks while working in the community and how to keep themselves safe.

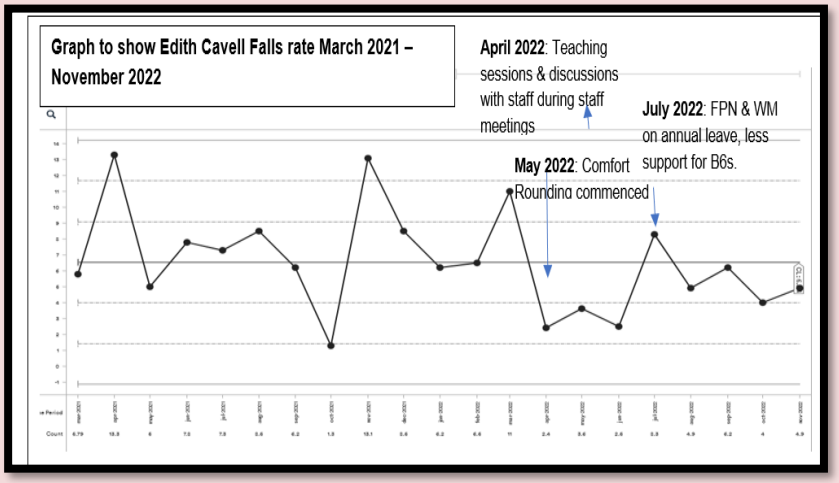
- Harm reported on Datix

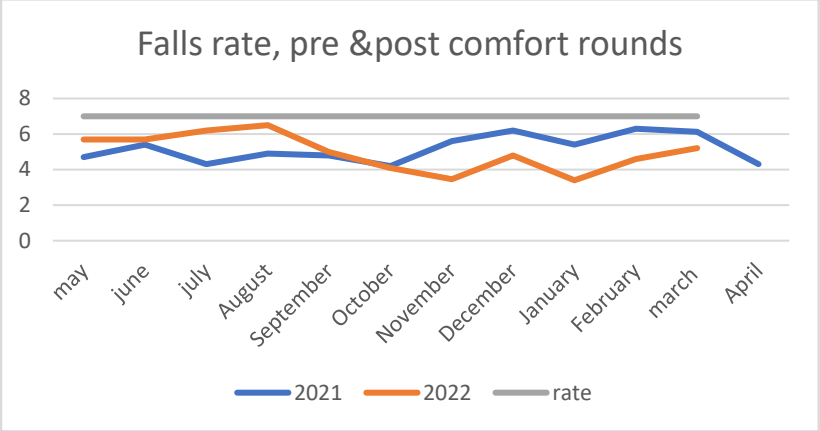


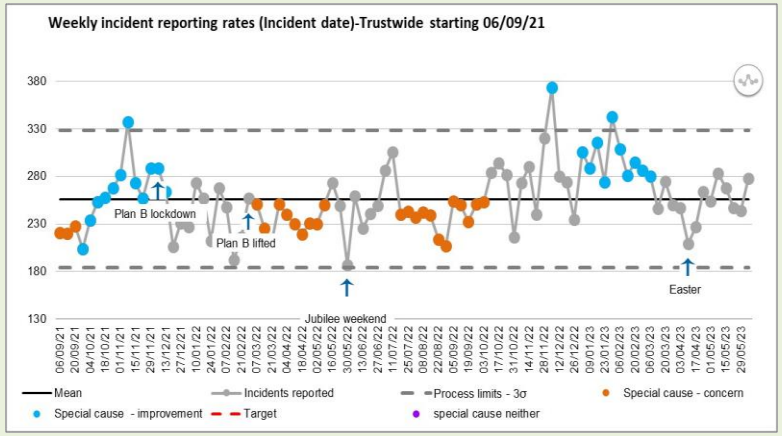
		➢ Work with our HPM team and ELFT colleagues to support training for staff on managing complex Mental Health patients	➢ Monthly usage of lone worker devices See table below

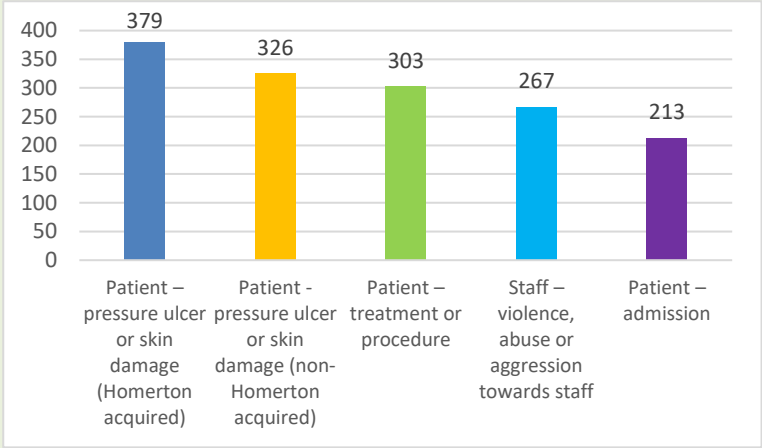
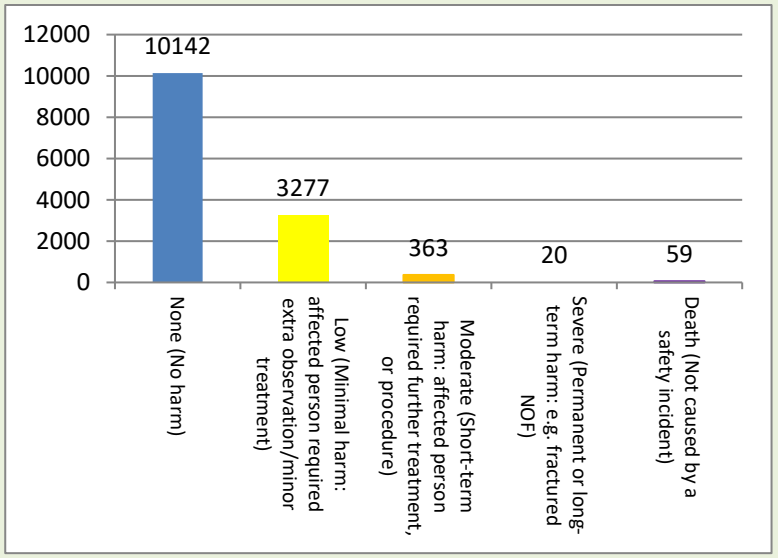
	January 2023	February 2023	March 2023
Total Devices Issued	551	551	551
Total Used Devices	79	68	66
Total Usage Level of Staff With Devices	14.3%	12.3%	11.9%

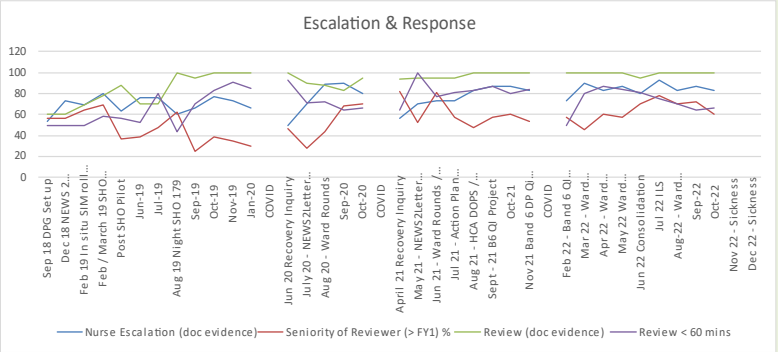
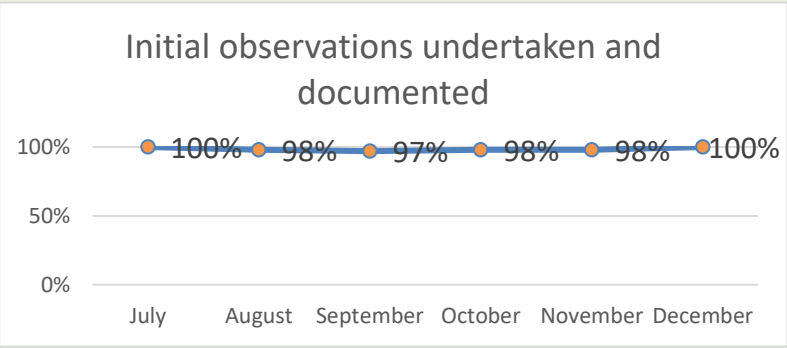
3. Improved management and reduction in the rate of falls **Domain:** **SAFE**	➢ Reduction in the rate measured by the Inpatient Falls Prevention Nurse (FPN)	**Progress made during 2022/23** ➢ 'Think Yellow' campaign has been launched, led by Falls Nurse. Support from QI team to review and monitor effectiveness. ➢ Relaunch in August 2022 when yellow socks stocked on the wards, in process of sourcing yellow star wrist bands to identify patients at risk of falls ➢ Comfort rounding launched on Edith Cavell ward, next steps to explore aspects of 'enhanced observation hierarchy' including cohorting/bay watch bays.	➢ Falls prevention QI project on Edith Cavell ward

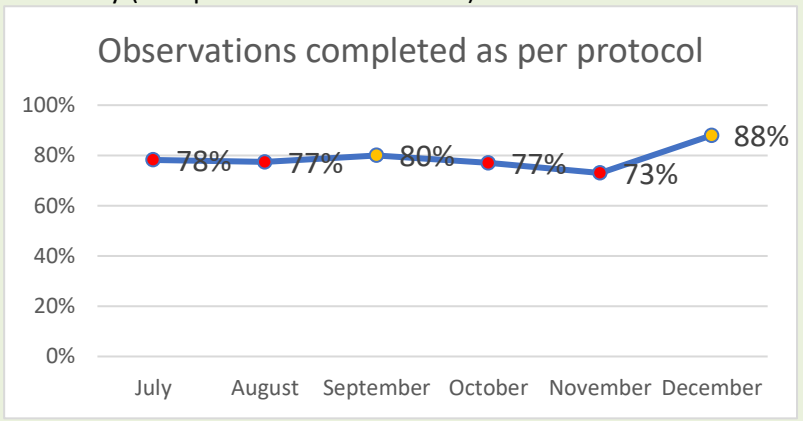
		➢ Post falls care – Algorithm developed and in situ simulation training rolled out for September and October. ➢ New post falls care algorithm developed and launched ➢ In situ simulation training being run over September and October introducing this algorithm ➢ Digital falls prevention training in development ➢ Pathway has been agreed which include MDT review and escalation to matrons ➢ Hot Debrief/after action reviews which are led by the falls nurse in falls with harm ➢ Falls team to offer training to ward managers about how to complete a hot debrief	
		Key steps going forward into 2023/24 ➢ Learning from QI project on Edith Cavell are now being transferred to other wards, with a plan to spread Comfort Rounding to Graham Ward. ➢ First level, E learning package agreed & developed which is suitable for all new clinical and non-clinical staff, band 2 and above. This will become part of the Trust's is mandatory package for all staff. (Compliance at 80% for all new staff trained within first year.) ➢ Investigate whether enhanced observation hierarchy, "Tag in, Tag out" and cohorting project has any benefit & whether MDT could participate. ➢ Hot debrief led by the fall's prevention nurse, completed with ward staff once a patient has fallen twice or more in Homerton wards within 2 days of the fall	➢ Reduction in falls rate noted following introduction of comfort rounds

		➢ Maintain “think yellow, think falls” initiative 2023/2034	

4. Just Culture and Safe Environment **Domain:** **SAFE & EFFECTIVE**	➢ New priority supporting, developing and promoting a just culture where staff feel safe to raise concerns.	**New priority for 2022-2024** ➢ Our Future Together - new strategy for the next five years launched. Six priorities that were developed close collaboration with our people, partners, patients, and local community; includes Develop happy, healthy & heard staff ➢ To be supported by the successful delivery of Our People Plan ➢ Psychological first Aid programme – support staff health and wellbeing ➢ Weekly warmer wellbeing programme including Trolley talk - highlighting (anonymously) what issues/ suggestions have been brought up with the Trolley owners and what we as a Trust are doing about it! ➢ Implementation of new Patient Safety Incident Response Framework o Task & finish group established o Draft policy and gap analysis to be submitted for approval during Summer 2023 o New incident response methodologies to be implemented, e.g. Patient Safety Investigations After action reviews, multidisciplinary review, or facilitated debrief ➢ Business case to scope additional roles of dedicated investigation leads. ➢ Recruitment of patient Safety Partners to be completed during 2023/24 ➢ Staff safety culture survey launched during Q1 2023/24. The survey will help us understand your thoughts on patient safety, incident reporting, and the culture Homerton has around this.	➢ Metrics will include: o The NHS Staff Survey People's reported experiences are an important measure of the plan's progress. o Employment resolution case numbers ➢ Freedom to Speak up interactions, trends and themes o 98 concerns recorded during Q1 2023/24; o Bullying/Harassment o Discrimination o Staff safety o Patient safety o Advice ➢ Incident reporting rates (weekly figures) 

		➢ Introduction of SEIPS framework for understanding outcomes within complex socio-technical systems. ➢ Implementation of new national incident reporting system (Learning From Patient Safety Events) ➢ Just Culture learning approach established with new resolution policies in draft to support a compassionate and learning based approach ➢ Freedom to Speak up process moved across to Datix to ease access and thematic analysis ➢ Ensuring safe environment for staff to raise patient safety concerns and Freedom to Speak up processes ➢ Carry forward activity from learning from incidents, patient experience and inquests	➢ Incidents reported by category Q4 2022/23 (top 5)  ➢ Incident reporting 2022/23 (by harm) 

5. Appropriate identification and management of deteriorating patients, including maternity, paediatrics and community based services **Domain:** **SAFE & EFFECTIVE**	➢ Expand the work completed for deteriorating adult inpatients to support maternity, paediatrics and community services.	**Progress made during 2022/23** ➢ Monthly audits completed in real time basis from EPR to review escalation enabling immediate remedial actions. ➢ Electronic Records are reviewed from previous 24 hours to identify point of deterioration, and identify if appropriate escalation has occurred ➢ Unplanned ITU admissions and patients with confirmed sepsis reviewed, KPI agreed with commissioners (antibiotics administered under 1 hour) ➢ Band 6 deteriorating patient QI project to raise awareness and MDT teaching across wards ➢ Simplified system for prescribing oxygen on EPR supported by weekly performance reviews shared with staff. ➢ Deteriorating Patient Oversight Group established during 2022/23 autumn to support community and maternity and paediatrics. **Key steps going forward into 2023/24** ➢ Adults - Improve frequency of recording of vital sign observations (with reference to NEWS score). This is a significant piece of work using multiple interventions to make improvements: ○ Updates to EPR process for inputting vital signs ○ Automatic update of vital signs onto EPR using vital links ○ Training of staff regarding NEWS score and frequency of observations ➢ Deteriorating Patient (adult) CQUIN launched for 2023/24 to provide oversight of activity across audit, maternity, paediatric and community services	➢ <u>Escalation and response data (adults)</u>  ➢ <u>Paediatrics</u> - Ongoing audit to collect data to look at CEWs escalation and unexpectedly deteriorating patients, with particular focus on time of response and documentation on electronic notes followed by thematic analysis (expected needs for further training for Doctors and Nurses on Optflow and CPAP initialization) ➢ <u>Maternity (NEWTT observation audit)</u> 

		➢ Acute Paediatric Deteriorating patient group has been formed with the plan to meet every 6-8 weeks and look into: ○ Ongoing measurement and results ○ monitor progress ○ Discussion and feedback of learning points of specific cases and identify positive case scenarios and "learning from excellence" ➢ CEWS- (paediatric) policy is currently being reviewed (policy and escalation thresholds being finalised. Currently having discussions regarding CEWS score on EPR and discrepancies with age. ➢ Maternity Escalation and Deteriorating Patient Group established during 2022/23 ➢ Maternity to continue NEWTT observations audit: ○ MOEWS - It has been planned and being implemented. We will study it prospectively in April 2023 ○ NEWTT: ○ Quality boards ○ Recommencement of case studies ○ Fresh Eyes from new inpatient matron starting 6 February 2023 ○ Rebranding of NEWTT trigger chart to ensure standardisation of escalation. ○ Recommence sharing of case studies to all staff ➢ Community Deteriorating Patient Group has been agreed for 2023/24 ➢ Community Workstreams to be developed during 2023/24	➢ Maternity (Completion of observations)  ➢ Community (to be established during 2023/24) ➢ CQUIN: Recording of and appropriate escalation and response to NEWS 2 scores for unplanned critical care admissions (to be included)

6. Improving our populations health **Domain:** **EFFECTIVE**	➢ Launch new Trust strategy "Our Future Together" ➢ Set up the Tobacco Dependence Treatment (TDT) Service at Homerton Healthcare ➢ Extend activity into other workstreams, e.g. diabetes, obesity etc.	**New quality priority supported by the launch of Our Future Together strategy.** **https://www.homerton.nhs.uk/download/doc/docm93jijm4n13362.pdf?amp;ver=30420** **Progress made during 2022/23** ➢ New Quality Priority under development supporting improvements in population health by working with our patients and our partners ➢ Working in collaboration with our partners, develop a model integrated care and health partnership in City and Hackney which makes a real impact on its priorities of: o giving every child the best start in life o improving mental health and preventing mental ill health o improving outcomes for people with long term health needs. ➢ Hackney Early Language Pathways project that is running in the Hackney Downs Neighbourhood. The QI team have provided regular coaching to the project lead, as well as support to create surveys and analyse data into themes. ➢ Continue working on the Autistic Friendly Neighbourhoods project in the London Fields Neighbourhood through regular coaching sessions with the project lead. ➢ Vocational Rehabilitation Occupational Therapy (VROT) clinic that is currently being trialled in Hackney Marshes.	New metrics to be established for 2023/24 ➢ National metrics for health inequalities ➢ National metrics for health and wellbeing for children and families ➢ Reporting metrics identified for smoking cessation 9 to be reported form April 2023 onwards): ➢ Number of inpatients screened ➢ Number of inpatient smokers provided the TDT service ➢ Number of inpatient smokers provided NRT ➢ Number of inpatients referred to the local stop smoking service

		➢ Homerton Our Future Together - new strategy for the next five years launched. Six priorities that were developed close collaboration with our people, partners, patients, and local community; includes Develop happy, healthy & heard staff ➢ Provide health promotion advice at every point of contact, wherever possible; including smoking cessation	
		Key steps going forward into 2023/24 ➢ Measures of health and wellbeing for children and families will be within the top quartile nationally ➢ A Trust mental health, learning disabilities and autism strategy will be implemented, ensuring that patients are cared for appropriately in the best setting and with dignity and respect ➢ People with long-term conditions will have reduced admission rates and length of stay year-on-year ➢ Link to community screening programmes and health improvement initiatives (smoking cessation, diabetes and obesity) ➢ Start part delivery to the inpatients smoking cessation service from April 2023 ➢ Recruit new staff member to deliver the smoking cessation service – aim to complete the recruitment by end of August ➢ Maintain work on the Smokefree Homerton Steering Committee ➢ Approval process for the NRT Protocol and Smokefree Policy ➢ Agree on the pathway and protocol between the inhouse TDT service and the local community stop smoking service	

		➢ Explore the potential of part funding of the inhouse smoking cessation service by the public health service ➢ Develop comms package to promote the smoking cessation service	

7. Improving the first impression and experience of the Trust for all patients and visitors **Domain:** **PATIENT EXPEREINCE**	➢ Improve patient satisfaction scores	➢ Supported by the launch of the Trust's 'Our Future Together' strategy; ➢ Actively seek out the experiences and stories of our patients and carers to improve and develop our services ➢ AccessAble created detailed access guides to facilities, wards and departments across the hospital. The guides help patients, visitors and staff plan their journeys to and around the hospital. ➢ Relocation of phlebotomy to Lower Clapton Health Centre to provide a better patient experience. ➢ Homerton Patient Voice; meets every other month to discuss areas of patient and user involvement and engagement within the Trust. The membership includes Homerton staff, as well as patient and patient organisation representatives. ➢ Actively seek out the experiences and stories of our patients and carers to improve and develop our services ➢ 'Our Estates plan' to review the fabric and environment of the Trust premises.	➢ Metrics to be developed, including feedback from o Friends and Family Test, o Patient Advice & Liaison Service (PALS) enquiries, o NHS Choices, o Care Opinion and o Complaints Outpatient satisfaction survey for Emergency Dept survey, Maternity & theatres, o Regular environmental audits, Customer care skills training targets.

Table 10: quality priority updates for 2022/23 and 2023/24

3.3 Performance against national indicators

3.3 Performance against national indicators

During 2021/22, as a consequence of Covid, the Trust's actual performance against national operational standards suffered (along with the rest of the country). However, given the circumstances, the Trust delivered a comparably strong operation performance against the suite of core standards. It should be noted that due to the Covid pandemic.

The following table sets out performance against the key indicators contained within the Risk Assessment Framework. The performance has been presented on a cumulative basis for the year, although we, as with all NHS trusts, were required to report to NHS on a range of measures monthly and/or quarterly.

Key Performance Indicators	Target	2020/21 Performance	2021/22 Performance	2022/23 Performance
A&E patients discharged <4hrs	95%	93.00%	86.93%	**80.59%**
Cancer				
2 Week Wait	93%	96.16%	94.43%	**93.56%**
31 Day Target	96%	98.43%	99.82%	**99.07%**
62 Day Target	85%	84.60%	82.88%	**79.76%**
Infection Control				
MRSA	0	5	1	**3**
Clostridium difficile (C.diff)	12	10	16	**24**
18 Week RTT Indicator				
Incomplete Pathways	92%	74.08%	80.17%	**80.49%**
IAPT Indicators				
6-week target	75%	98.02%	98.22%	**97.28%**
18-week target	95%	99.68%	99.76%	**99.32%**

Table 11: national indicators

Monitoring quality and performance

Performance against key metrics is monitored and reviewed by the executive directors at senior team meetings. The Trust Board considers detailed performance and quality information each month.

Annex

1.0 Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

1.1 Healthwatch Hackney

Healthwatch Hackney thanks Homerton Healthcare for the opportunity to comment on the Quality Account Report.

We commend Homerton Healthcare on the achievement of "outstanding" for the acute hospital and "good" for the trust against CQC ratings, and note that, in our recent trends analysis report, comments drawn from a wide variety of sources showed 77% of patients shared positive comments around quality. Following a suspension of comment collection during the pandemic, Healthwatch Hackney has now resumed monthly visits to Homerton Hospital for comment collection. As a result, the amount of patient experience data that we are collecting is increasing, leading to more meaningful reports. We look forward to continuing to use these reports to work in partnership to improve patient experience.

Healthwatch Hackney is particularly delighted to see the update on page 71 around priority 7 (Improving the first impression and experience of the Trust for all patients and visitors). We felt there were some excellent examples of collaborative working and patient involvement in this work, such as the storytelling event and wider engagement that fed into the Trust's 'Our Future Together', and the collaborative work with local residents to shape the Homerton Voice forum.

We recommend Homerton Healthcare works with Healthwatch Hackney to ensure effective use of patient feedback to improve patient experience by sharing all patient feedback received through Complaints, PALS and Compliments services and Friends and Family Test. Healthwatch Hackney patient/public groups can then review the feedback to propose meaningful recommendations or undertake additional engagement work where appropriate.

We note the extensive work around maternity, and would re-iterate the Healthwatch Hackney recommendations drawn from our report (The experience of maternity care in Hackney".

- A vision for co-production of antenatal care and support with service users especially for GP services

- Hospital and community maternity services should consider using different methods of engagement to review the levels of postnatal support to women in Hackney.
- External information – We recommend further engagement with women to ensure that health professionals including GPs can guide women to 'approved' trusted sources of information and advice which can include online apps as well as offline support for those who are digitally excluded. Starting in 2023 Healthwatch Hackney will be developing resources for women based on local experiences which we hope will fill this gap.
- Ensure that a patient information leaflet detailing contact information about available support (e.g. what is classified as an emergency, what to do in an emergency, language and advocacy support, what to expect during pregnancy, option to provide feedback etc,), is provided to all women during their pregnancy as a matter of routine at the time of the pregnancy announcement (at the GP or other services).

Healthwatch Hackney has been pleased to see the strong leadership Homerton Healthcare has shown in working with the local integrated place-based partnership, under the leadership of Louise Ashley. We look forward to continued partnership working in the future.

With many thanks,

Sally Beaven
Executive Director (acting)
Healthwatch Hackney

1.2 Overview and Scrutiny Committee

Overview & Scrutiny

Health in Hackney Scrutiny Commission
Hackney Council
Town Hall
Mare St,
London E8 1EA

Reply to: jarlath.oconnell@hackney.gov.uk

23 June 2023

Ms Louise Ashley
Chief Executive
Homerton Healthcare NHS Foundation Trust
Trust Offices
Homerton Row
London E9 6SR

Email to: louise.ashley@nhs.net, breeda.mcmanus1@nhs.net *and* matthew.grantham1@nhs.net

Dear Louise

Response to Homerton Healthcare NHS Foundation Trust's draft Quality Account for 2022/23

Thank you for inviting us to submit comments on the Draft Quality Account for your Trust for 2022/23. We are writing to provide our insights arising from the scrutiny of the Trust's services over the past year at the Commission.

We've been grateful for the continued support to the scrutiny function of yourself and your colleagues and for your continuing leadership role as Place Based Leader for City & Hackney.

Over the past year at our Commission we've had the following items which touched on your Trust:

- Development of new City and Hackney Place Based Partnership and the role of the Place Based Leader x 3
- Mental health emergency department pressures at Homerton
- Future options for Soft Facility Services at Homerton Healthcare
- Community Diagnostic Centres
- Impact of new hospital discharge funding scheme

We do appreciate the Quality Account exercise as it allows us also to step back from individual issues we raise with you over the course of the year and take an overview of the quality of your services. The Commission Members take a great interest in the performance of our key local acute trust and we're pleased to learn about some of your key achievements over the past year.

We're pleased that the overall CQC rating for both the Homerton and Mary Seacole sites remain unchanged at 'Good' despite the pressure of having to rebuild elective care post the pandemic and increased winter pressures.

We support the 7 quality priorities you had identified in 2022:

1	To reduce the number of community and hospital attributed pressure ulcers
2	Reducing physical violence and aggression towards patients and staff
3	Improved management and reduction in the rate of falls
4	Just Culture and Safe Environment
5	Appropriate identification and management of deteriorating patients, including maternity, paediatrics and community-based services
6	Improving our populations health
7	Improving the first impression and experience of the Trust for all patients and visitors

and that they are in place for a 2 year reporting cycle to ensure that sufficient and sustainable progress can be achieved with them. We commend the progress you are reporting thus far.

We noted with interest the following:

a) We note that the KPI for *A&E patients being discharged in less than 4 hrs* is at 80.59% and has fallen for the second year in a row and so remains below the target of 95%. The Trust historically performed really well on this and, while this is a challenging time for the NHS nationally, we look forward to hearing more about the context here and the mitigation plans.
b) Similarly, the KPI on the number of cases of *Clostridium difficile* has spiked from 16 to 24, as against the target of 12, and we'd be interested to know more about the reasons and the mitigation plans.
c) We commend the continued excellent performance of the IAPT service on the 6 and 18 week targets.
d) We commend too, the ongoing and very active role that the Trust plays in clinical research and your participation in national audits, as these will contribute to improving treatments and outcomes for our residents.

Over the coming year, and following our discussions, we will be revisiting a number of issues including: Emergency Dept mental health case management and in-patient capacity; the planned changes to Continuing Health Care, and health inequalities and medical barriers faced by the trans community. In January we hope to hear back on the future options for 'soft facility services' at Homerton Healthcare.

Members have also expressed concerns on such issues as: poor maternity health outcomes for Black women; poor prostate cancer health outcomes for Black men and the spike in rates of sexually transmitted infections. We are still refining our work programme for 23/24 and will get back to you on those which have direct relevance to yourselves.

We commend the report and are pleased that the Trust performs so strongly against a wide range of national quality assurance indicators.

Yours sincerely

Councillor Ben Hayhurst
Chair of Health in Hackney Scrutiny Commission

cc Breeda McManus, Chief Nurse and Director of Governance, Homerton Healthcare
Matthew Grantham, Deputy Head of Quality and Patient Safety, Homerton Healthcare
Members of Health in Hackney Scrutiny Commission
Cllr Christopher Kennedy, Cabinet Member for Health, Adult Social Care, Voluntary Sector and Culture
Dr Sandra Husbands, Director of Public Health, City and Hackney

1.3 Commissioners Statement for Homerton Healthcare NHS Foundation Trust 2022/23 Quality Account

North East London

Commissioners Statement for Homerton Healthcare NHS Foundation Trust 2022/3 Quality Account

NHS North East London Integrated Care Board is the lead commissioner responsible for commissioning health services from Homerton Healthcare NHS Foundation Trust on behalf of the population of east London.

Thank you for asking us to provide a statement on Homerton Healthcare NHS Foundation Trust's 2022/23 Quality Account and priorities for 2023/24.

We recognise that the impact of the pandemic is still being felt, with increased pressure on services and tackling the backlog of elective care. Despite this, we commend the measures and steps the trust have taken to ensure services are performing well against national and local quality measures. We note the trust continues to perform well against the 4-hour A&E treat/discharge target, being one of the best performing trusts nationally. We are aware of the continued effort the trust makes in improving the more challenging services, especially the 62-day cancer waiting times by redesigning several cancer pathways.

We applaud the continued progress of the seven priorities carried forward and welcome the new Our Future Together strategy which supports a Just Culture and Safe Environment and Improving Our Population Health priorities. We welcome the key steps going forward for each priority. We note that despite increasing demands the trust continues to report high patient satisfaction with the Friends and Family Test data showing an upward trend in patient satisfaction over the past year.

We are aware that the trust has undertaken important work to address health inequalities in the last year and we welcome the new metrics to be established for 2023/24: metrics on health inequalities and for health and wellbeing for children and families.

We are grateful to Homerton Healthcare NHS Foundation Trust and its staff for their commitment to collaboration and partnership working that will further support and develop our North East London Integrated Care System.

We confirm that we have reviewed the information contained within the Account, and checked this against data sources where these are available to us, and it is accurate.

Overall, we welcome the 2022/23 quality account and look forward to working in partnership with the trust over the next year.

Zina Etheridge
Chief Executive Officer
North East London Integrated Care Board

2.0 Statement of directors' responsibilities for the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

• the content of the quality report meets the requirements set out in the *NHS foundation trust annual reporting manual 2020/21* and supporting guidance *Detailed requirements for quality reports 2019/20.* No specific guidance was issued for 22/23

• the content of the quality report is not inconsistent with internal and external sources of information including: – board minutes and papers for the period April 2022 to March 2023

– papers relating to quality reported to the board over the period April 2022 to March 2023

– feedback from commissioners dated June 2023

– feedback from governors dated June 2023

– feedback from local Healthwatch organisations dated June 2023

– feedback from overview and scrutiny committee dated June 2023

– the latest national patient survey completed September 2022

– the latest national staff survey published November 2022

– CQC inspection report dated January 2022

• the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered

• the performance information reported in the quality report is reliable and accurate

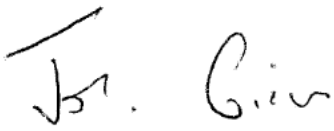
• there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice

• the data underpinning the measures of performance reported in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review

• the quality report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality accounts regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board



Sir John Gieve
Chair of the Board of Directors
29/06/23

Louise Ashley
Chief Executive
29/06/23

Appendices

Appendix 1: National Audits reviewed 2022/2023

National programme name	Work stream / Topic name	Eligible	Participated	Status
Breast and Cosmetic Implant Registry	-	✓	TBC	Data Collection from Jan 2022 – December 22. Report Published 02/03/2023. PARTICIPATION DATA TO BE CONFIRMED
Case Mix Programme (CMP)	-	✓	✓	On-going Data Submission
Child Health Clinical Outcome Review Programme	Testicular torsion (NCEPOD)	✓	✓	Questionnaires to be Submitted by 30/06/2023
	Transition from child to adult health services (NCEPOD)	✓	✓	Data Submitted 100%
Elective Surgery (National PROMs Programme)	-	✓	✓	On-going Data Submission
Emergency Medicine QIPs	Assessing cognitive impairment in older People	✓	✓	On-going Data Submission
	Consultant Sign Off - 6 months only Apr-Oct 2022	✓	✓	2022 Audit Report Published April 2023 - Action Plan with lead
	Infection Prevention and Control	✓	✓	On-going Data Submission
	Mental Health self-harm	✓	✓	On-going Data Submission
Epilepsy 12 - National Audit of Seizures and Epilepsies for Children and Young People	Epilepsy12 has separate workstreams/data collection for: Clinical Audit, Organisational Audit	✓	✓	On-going Data Submission
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls	✓	✓	On-going Data Submission
	National Hip Fracture Database	✓	✓	On-going Data Submission
National Gastro-intestinal Cancer Audit	National Bowel Cancer Audit	✓	✓	On-going Data Submission
	National Oesophago-Gastric Cancer Audit (NOGCA)	✓	✓	On-going Data Submission
Inflammatory Bowel Disease Audit	-	✓	✗	Did not Participate – data collection constraints.

				Additional resources identified for 2022-3/24
LeDeR - learning from lives and deaths of people with a learning disability and autistic people Previously known as Learning Disabilities Mortality Review Programme	-	✓	✓	Data Submitted. NEL 2022 -2023 Report to be published in August 2023. National Report to be published in July 2023.
Management of the Lower Ureter in Nephroureterectomy Work streams previously listed under Urology Audits.	Management of the Lower Ureter in Nephroureterectomy	✓	✓	On-going Data Submission
Maternal, Newborn and Infant Clinical Outcome Review Programme	Maternal mortality surveillance and confidential enquiry (confidential enquiry includes morbidity data)	✓	✓	On-going Data Submission
	Perinatal confidential enquiries	✓	✓	On-going Data Submission
	Perinatal mortality surveillance	✓	✓	On-going Data Submission
Medical and Surgical Clinical Outcome Review Programme	Community Acquired Pneumonia (NCEPOD)	✓	✓	Participated
	Crohn's disease (NCEPOD)	✓	✓	Participated
	End of Life Care (NCEPOD)	✓	✓	Audit to Start during 2023/2024
	Endometriosis (NCEPOD)	✓	✓	Data Requested and submitted, cases selected by NCEPOD. – Audit commencing in 2023/2024
	Epilepsy Study (NCEPOD)	✓	✓	2021-2022 NCEPOD Report Published in December 2022. Not a current NCEPOD Study for 2022/23

	Physical Health in Mental Health Hospitals (NCEPOD)	✓	✓	2021-2022 NCEPOD Report Published in May 2022. NCEPOD Study for 2022/23
Mental Health Clinical Outcome Review Programme	Suicide by people in contact with substance misuse services	✓	TBC	2021-2022 Report Published in March 2023
National Adult Diabetes Audit (NDA)	National Diabetes Foot Care Audit (NDFA)	✓	✓	On-going Data Submission
	National Diabetes Inpatient Safety Audit (NDISA) Previously NaDIA-Harms	✓	✓	On-going Data Submission
	National Core Diabetes Audit	✓	✓	Participated
	National Diabetes in Pregnancy Audit	✓	✓	On-going Data Submission
	National Diabetes Transition (linkage with NPDA)	✓	✓	On-going Data Submission
	NDA Integrated Specialist Survey	✓	✓	On-going Data Submission
National Asthma and COPD Audit Programme (NACAP)	Adult Asthma Secondary Care	✓	✓	On-going Data Submission
	Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	On-going Data Submission
	Paediatric Asthma Secondary Care	✓	✓	On-going Data Submission
	Pulmonary Rehabilitation Organisational and Clinical Audit	✓	✓	On-going Data Submission
National Audit of Cardiac Rehabilitation	-	✓	✓	On-going Data Submission
National Audit of Care at the End of Life (NACEL)	-	✓	✓	Participated in Round 4. Data Submission Closed. Report due July 2023
National Audit of Dementia	Care in General Hospitals	✓	✓	On-going Data Submission
	Spotlight Audit for Memory Assessment Services	N/A	N/A	Participation by NELFT, service run by NELFT not HHFT.
National Bariatric Surgery Register	-	✓	✓	On-going Data Submission

National Cardiac Arrest Audit (NCAA)	-	✓	✓	On-going Data Submission
National Cardiac Audit Programme (NCAP)	Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	On-going Data Submission
	National Heart Failure Audit	✓	✓	On-going Data Submission
National Child Mortality Database (NCMD)	-	✓	✓	On-going Data Submission – Data is submitted to CDOP. WELC submit data to NCMD for C&H
National Comparative Audit of Blood Transfusion	2021 Audit of Blood Transfusion against NICE Guidelines	✓	✘	HHFT not participate in 2022/2023 as transferred to Pathology Partnership. Interest has been expressed for 2023/2024
National Early Inflammatory Arthritis Audit	-	✓	✓	On-going Data Submission
National Emergency Laparotomy Audit (NELA)	-	✓	✓	On-going Data Submission
National Head and Neck Cancer Audit (HANA)	-	✓	✓	On-going Data Submission
National Joint Registry	10 workstreams that all report within Annual report: • Primary hip replacement • Primary knee replacement • Primary shoulder replacement • Primary elbow replacement • Primary ankle replacement • Revision hip replacement • Revision knee replacement • Revision shoulder replacement • Revision elbow replacement	✓	✓	On-going Data Submission

	• Revision ankle replacement			
National Lung Cancer Audit	-	✓	✓	On-going Data Submission
National Maternity and Perinatal Audit (NMPA)	-	✓	✓	On-going Data Submission
National Neonatal Audit Programme (NNAP)	-	✓	✓	On-going Data Submission
National Perinatal Mortality Review Tool	-	✓	✓	On-going Data Submission
National Prostate Cancer Audit (NPCA)	-	✓	✓	On-going Data Submission
Out of hospital cardiac outcomes (OHCAO)	-	✓	✓	On-going Data Submission
Respiratory Audits	Adult Bronchiectasis Audit	✓	✓	On-going Data Submission
	Adult Respiratory Support Audit	✓	✓	On-going Data Submission
	Smoking Cessation Audit- Maternity and Mental Health Services	✓	✓	On-going Data Submission
	National Outpatient Management of Pulmonary Embolisms Audit	✓	✓	On-going Data Submission
Sentinel Stroke National Audit Programme (SSNAP)	-	✓	✓	Participated
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	-	✓	✓	On-going Data Submission
Society for Acute Medicine Benchmarking Audit (SAMBA)	-	✓	✗	Data collection constraints. Additional resources identified for 2022-3/24
Transurethral REsection and Single instillation intra-vesical chemotherapy Evaluation in	-	✓	✓	On-going Data Submission

bladder Cancer Treatment (RESECT) Improving quality in TURBT surgery.				
Trauma Audit & Research Network (TARN)	-	✓	✓	On-going Data Submission
UK Parkinson's Audit	-	✓	✓	Participated

Table 12: National clinical audits applicable to the Trust - source internal Trust records

Cancelled audits – 1 cancelled Nationally

- National Audit of Breast Cancer in Older Patients (NABCOP)

Audit Postponed

No relevant Audits were postponed during this audit period.

Audit Not Relevant to the Trust

There were 31 national clinical audits that were not applicable to the Trust, see table 3.

National programme name	Audit Name	Reason
British Spinal Registry	-	Not Relevant to Trust
Cleft Registry and Audit Network (CRANE)	-	Not Relevant to Trust
Falls and Fragility Fracture Audit Programme (FFFAP)	Fracture Liaison Service Database (FLS-DB)	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Real-time surveillance of patient suicide	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Suicide (and homicide) by people under mental health care	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Suicide by middle-aged men (Topic closed 2021/22)	Not Relevant to Trust
Mental Health Clinical Outcome Review Programme	Suicide by people in contact with substance misuse services	Not Relevant to Trust
National Audit of Cardiovascular Disease Prevention Primary care	-	Not Relevant to Trust
National Audit of Dementia	Spotlight Audit for Memory Assessment Services	Not Relevant to Trust
National Audit of Pulmonary Hypertension	-	Not Relevant to Trust
National Cardiac Audit Programme (NCAP)	National Adult Cardiac Surgery Audit	Not Relevant to Trust
National Cardiac Audit Programme (NCAP)	National Audit of Cardiac Rhythm Management (CRM)	Not Relevant to Trust
National Cardiac Audit Programme (NCAP)	National Audit of Percutaneous Coronary	Not Relevant to Trust

	Interventions (PCI) (Coronary Angioplasty)	
National Cardiac Audit Programme (NCAP)	National Congenital Heart Disease Audit (NCHDA)	Not Relevant to Trust
National Clinical Audit of Psychosis (NCAP)	EIP audit 2021/22	Not Relevant to Trust
National Ophthalmology (NOD)	Age-related Macular Degeneration Audit (AMD)	Not Relevant to Trust
National Ophthalmology Audit (NOD)	Adult Cataract Surgery	Not Relevant to Trust
National Paediatric Diabetes Audit	-	Not Relevant to Trust
National Vascular Registry	-	Not Relevant to Trust
Neurosurgical National Audit Programme	-	Not Relevant to Trust
Paediatric Intensive Care Audit Network (PICANet)	-	Not Relevant to Trust
Perioperative Quality Improvement Programme (PQIP)	-	Not Relevant to Trust
Prescribing Observatory for Mental Health	Improving the quality of valproate prescribing in adult mental health services	Not Relevant to Trust
Prescribing Observatory for Mental Health	Prescribing for depression in adult mental health services	Not Relevant to Trust
Prescribing Observatory for Mental Health	Prescribing for substance misuse: alcohol detoxification in adult mental health inpatient services	Not Relevant to Trust
Prescribing Observatory for Mental Health	Prescribing of antipsychotic medication in adult mental health services, including high dose, combined and PRN	Not Relevant to Trust
Prescribing Observatory for Mental Health	Use of clozapine	Not Relevant to Trust
Prescribing Observatory for Mental Health	Use of melatonin	Not Relevant to Trust
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry	UK Renal Registry Chronic Kidney Disease Audit	Not Relevant to Trust
Renal Audits Previously listed under Chronic Kidney Disease Registry and/or UK Renal Registry	National Acute Kidney Injury Audit	Not Relevant to Trust
UK Cystic Fibrosis Registry	-	Not Relevant to Trust

Table 13; National audits not applicable to the Trust – source internal Trust records

Appendix 2: Implementation of actions implemented following the publication of the national audit and local audit 2022/2023

AUDIT TITLE	GOOD PRACTICE	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
National Maternity and Perinatal Audit Clinical Report	Based on births in NHS maternity services between 1 April 2018 and 31 March 2019 in England and Wales The report captures 89% of eligible births, finding that one third of mothers with singleton pregnancies at term underwent an induction of labour. Other key findings include: • Of those experiencing an instrumental birth by forceps, as many as 1 in 20 did so without an episiotomy. • Of those opting for a vaginal birth after a previous caesarean birth, the proportion who went on to experience a vaginal birth was 61% • Of those experiencing their first birth, 23% had an instrumental birth, 23% had an emergency caesarean, and 44% who had a vaginal birth had an episiotomy.	(1) Improve the availability and quality of information about possible interventions during labour and birth, by offering individualised evidence-based information in a language and format which is accessible and tailored to each woman or birthing person's circumstances. Consider using the IDECIDE decision-making and consent tool (when available) (2) All women and birthing people should be routinely counselled and offered an episiotomy prior to experiencing a forceps-assisted birth, to reduce the chance of an OASI. (3) Conduct reviews of data completeness, data capture software and practices including mandatory field requirements. Utilise user feedback to identify patterns in missing data and opportunities to support healthcare professionals to provide complete data without	(1) IDECIDE tool not implemented but Maternity has a BAME Antenatal Group and the normal Antenatal Groups should be commencing soon. (2) Local guideline states to undertake episiotomies at forceps and there have been two cases in the last 6 months without episiotomy and these were reported on Datix and investigated. Prompt on K2 'Consider Abandoning Procedure if Delivery is NOT Imminent with 3 pulls.' (3) Contracts were awarded to Clevermed Ltd in March 2022 with a current go live date estimated around May/June 2023. However, the digital midwives run daily reports to ensure date is captured correctly and accurately for MSDS validation. This ensures that any issues with missing or incorrect data is actioned appropriately. Feedback is given to staff where necessary to support them to improve with accurate data capture and documentation. (4) Recorded on Maternity Dashboard. If not, Consultant Obstetric Anaesthetic can provide data.

		compromising clinical care. (4) Amend data fields to: ● collect the availability and timeliness of epidural anaesthesia ● separate the recording of intrapartum analgesia by type for both England and Wales ● collect analgesia and anaesthesia into two separate fields and enhance anaesthesia coding granularity to capture epidural, spinal or general anaesthesia separately in Wales.	
National Audit of Seizures and Epilepsies (Epilepsy12) and National Clinical Audit of Seizures and Epilepsies for Children and Young People	The report found that 70% (1379 out of 1974) of children and young people diagnosed with epilepsy had evidence of an updated and agreed comprehensive care plan. Other key findings include: • 65% (75 out of 115) Trusts and Health Boards had an adult epilepsy specialist nurse routinely involved in the transition of young people to adult services	(1) All females of child-bearing potential prescribed Sodium Valproate should have ongoing documentation regarding their status within the valproate Prevent Programme.	(1) The females of potential childbearing age are seen in epilepsy clinic 2-3 times a year and documentation completed with young person and parent/carer. Documentation kept on file and copy sent to GP.
Falls and Fragility Fracture Audit Programme (FFFAP)	National Audit of Inpatient Falls (NAIF) Based on 1,956 fragility fractures in 2020 and 2,033 fragility fractures in 2021, the number receiving FLS assessment within 12 weeks was	(1) Local health boards should ensure that they have appointed an Orthogeriatrician and that they actively support their leadership of multidisciplinary care in each trauma unit.	(1) Consultant Orthogeriatrician leads the MDT care of hip fracture patients. This is through clinical care on the wards, leading MDT meetings and leading the trusts hip fracture steering group.

	similar in 2020 and 2021 (64% and 65% respectively**)**	(2) Local health boards should ensure that falls teams in acute, community and mental health hospitals are included in quality improvement activities and are using the data from the National Audit of Inpatient Falls. (3) With falls teams reviewing health board level data and implementing focused quality improvement interventions should help improve the quality and safety of care in hospitals. (4) Health boards without an FLS should contact the Royal Osteoporosis Society and use their implementation toolkit to support them in preparing a business case. (5) Health boards that already have an FLS should ensure it is actively participating in the FLS-DB, and meeting its expected outcomes as defined by the FLS-DB's set of KPIs.	(2)The trust has a monthly strategic falls group where quality improvement projects are discussed to support inpatient falls prevention and management. Data from the National audit of inpatient falls, and data from our falls nurse and patient safety team guide the projects. (3)Progress on quality improvement projects are reviewed in the strategic falls group. Priorities for 2023/24 include enhanced observation, hot debriefs and recording of multifactorial falls risk assessment on EPR.
RCEM Fractured Neck of Femur (Care in Emergency Departments)	Over a period of 6 months, this RCEM QIP has accumulated 13949 individual cases from 159 emergency departments nationwide. This report represents a large scale national QIP delivered over a shared platform. • 49% of patients had their pain assessed	(1) Every ED should have a fractured neck of femur pathway and apply QI methodology to improve; a. time to pain assessment, b. time to analgesia, c. time to x-ray and, d. time to FIB.	(1)his is currently ongoing. Active QIP to concentrate particularly on speeding up time to XR and FIB. The aim is to prioritise these patients. NOF pathway already in situ. Due for an update (2)ED medical lead currently for hip fracture steering group. Regular

	on arrival at hospital within 15 minutes. • 56% of patients had received an X-ray within 90 minutes.	(2) Every ED should have nursing and medical leads for FNOF to champion the cause and steer improvement work. (3) Every ED should have nursing and medical leads for FNOF to champion the cause and steer improvement work. (4) Every ED should use a behavioural pain scoring tool for patients with cognitive impairment. (5) Triage nurses need to be supported and assisted in delivering timely and effective initial analgesia to any patient presenting with moderate or severe pain This would form the basis of an important QI project in itself. (6) Departments that have seen local improvements are encouraged to share good practices and submit case studies to RCEM.	meetings. No ED nursing lead for this at the moment. (3)This has now been implemented in our new AE fractured NOF ad hoc form (Abbey pain score). (4)Ongoing QIP. Awaiting first PDSA cycle. (5)This is ongoing for all patients with moderate or severe pain. Previous QIP.
National Child Mortality Database (NCMD)	Thematic report based on data collected from April 2019 to March 2021. (1) Changes in perinatal care, to reduce disease (e.g., reductions in preterm births, or brain injuries), or the impact of them (e.g., preterm brain injuries) are likely to have broad benefits to children, society and healthcare institutions	(1) Make prevention of preterm birth a priority. Social initiatives to reduce or mitigate the social determinants (e.g., smoking, obesity, and deprivation) require resources and support. Commissioners should seek to reduce deprivation and housing	(1)a) Maternity Consultant Lead for Preterm Birth runs a regular Preterm Birth Clinic. Preterm Care Bundle has been implemented including Fibronectin at Homerton. As part of the service an annual audit of preterm birth is conducted. (b) High BMI and Pregnancy Clinic is Consultant Led.

	across at least the first decade of life. Effective evidence-based perinatal interventions to reduce preterm mortality and brain injury exist (BAPM Toolkit; PERIPrem), however significant regional variation in clinical use has been noted. (2) The Perinatal Excellence to Reduce Injury in Premature Birth **(**PERIPrem) evidence-based perinatal care bundle has achieved a reduction in preterm mortality and brain injury in the South-West region after implementation.	insecurity, by integrating advice on employment, benefits and housing into maternity services, using health justice partnership and/or social prescribing models. Dedicated preterm birth clinics and implementation of evidence-based packages to predict and prevent preterm birth would ensure best-possible care to women according to their individual risk. (2) Ensure that the NICE Quality Standard QS116, which covers services for domestic violence and abuse in adults and young people, is used to improve the quality of care provided in this area. (3) Ensure broad and equitable implementation of evidence-based care bundles and single interventions (e.g., antenatal corticosteroids and magnesium sulphate) that reduce the impact of preterm birth. Delivery of all evidence-based therapies should be supported and benchmarked and compared between healthcare providers. (4) Ensure broad and equitable implementation of	(2)Maternity - Consultant Midwife/Public Health Lead Midwife oversees the Maternity Safeguarding Team which consists of Perinatal Mental Health Midwife, Safeguarding Midwife, Substance & Alcohol Misuse Midwife who case load women who fall under this category. Each area (zone) in the community is led by a Public Health Lead Midwife who oversee each area. Consultant Midwife/Public Health Lead Midwife works closely with different services across the Trust and different organisations ensuring the safest care can be provided for the vulnerable patients. (3)Magnesium Sulphate for Neuroprotection of the Fetus in Women at Risk of Preterm Birth already in place and local guideline in place. (4)NEWTT already in place. (5)*Maternity* - Local Learning Disabilities in Maternity Services guidance is already in place and implemented to local Practice. *Community Paediatrics* - Focussed and personalised care is provided to children with learning difficulties. Children in special needs schools as well as children in mainstream schools with LD are regularly reviewed by all the

		evidence-based bundles, care packages and single interventions that reduce the incidence and impact of brain injury around birth. Delivery of all evidence-based therapies should be supported and benchmarked between healthcare providers. In addition, the effective use of the Newborn Early Warning Trigger and Track (NEWTT) tool can reduce the severity of illness for babies who deteriorate after birth. (5) Improve parental and professional awareness of risk factors in children with learning disabilities (particularly the need for good nutrition, maintaining activity levels, avoidance of constipation, and appropriate responses to respiratory infections). (6) Ensure staff are aware of the importance of interpreting services being provided by professional interpreters at all stages of care, alongside provision of interpreting and translation services in NHS Trusts and all healthcare	relevant professionals including community paediatrics, dieticians, PT, OT and SALT. This helps to identify any complications early and get the specialist tertiary services input early. Most recently, the development of the PAC clinic proforma has helped to ensure compliance by prompting regular review of these factors more formally. (6)*Maternity* - Staff are encouraged to use Bigword. Maternity Unit is working towards acquiring Language Line that can enable better and immediate translation service when required via video consult. *Community Paediatrics* - In line with trust policy, we use advocacy service when indicated. For all appointments, admin staff ask whether interpreter services are needed. Ideally advocates are used face to face with telephone options when needed. Staff know and continue to be encouraged not to use family members for interpreting. (7)*Maternity* – Matron for Antenatal Clinic and Community is in the process of identifying the leads for the 5 different parts of the BCP. (8)*Maternity* - If the baby's death meets the Perinatal Mortality Review Tool (PMRT)

		services that provide care for women during pregnancy and beyond. (7) Implement provision of resources within the NHS [https://bills.parliament.uk/bills/3022] alongside programs such as the National Bereavement Care Pathway for Pregnancy & Baby Loss to support palliative care for the child, the family, and the clinical team. (8) Ensure that parents' views are sought and recorded as part of the child death review process. There was limited information from the CDOP process regarding parents' own views and concerns about their child's care during their child's life and death. The Child death review statutory and operational guidance requires parents' views to be sought and included in the process, however this is not yet happening in all cases. It will be important to find ways to improve this in future to help guide initiatives and support. (9) Ensure there is adequate multi-agency input into data collection and reviews so that	Criteria, parents ae routinely asked for their input. This is recorded on EPR within the progress notes section. Cases meeting the PMRT criteria are reviewed weekly for MDT review with Maternity and Neonatal Team. Learning drawn are shared with staff. *Community Paediatrics* - We have a substantive position for CDR nurse. Her role encompasses these aspects to include routinely submitting feedback from parents to meetings which is recorded on form C. (9) *Community Paediatrics* - Information is routinely collected across agencies at each child death review using standardised forms and incorporated into meeting papers for consideration and analysis. Relevant factors are recorded in Form C Analysis papers and in CDOP review forms.

		social environment factors, e.g., factors relating to safeguarding and deprivation, are appropriately collected and included for review.	
National Emergency Laparotomy Audit (NELA)	Homerton again outperformed in all recordable parameters with 100 % case ascertainment (86 cases) as compared to the national average of 84.5%(national standard 85%). All the Data for that period has been checked and cases has been locked. • Documentation of pre-operative risk assessment is 94.2% as compared to the national average of 84.0% (standard 85%). • 87.5% of the cases had access to theatres within the clinically appropriate time as compared to the national average of 82.8%. we can try and increase it to 100%. • The risk adjusted Mortality at Homerton Hospital is 8.7 % as compared to the national average of 9.3%. Most of the Mortality cases have been discussed in the appropriate Clinical governance/ MDT forum and mortality review tool has been updated. • 100% of the cases with predicted mortality > 5% were managed by the anaesthesia and general surgery consultant at Homerton	(1) The reporting of the CT scan by consultant is 67% which is still better than the national and AHSN 50% and 48% respectively. There is a room of improvement to increase it to around 80%. (2)	(1) The NELA pathway for management of emergency laparotomy will be included in the latest Emergency general Surgery policy which is in development

	Hospital. This is again much better than the 77.1% national average with minimum standard of 80%. • 82.6% of the patient aged above 80 and over 65 and frail were reviewed by the consultant geriatrician. This is far better than the national average of 28.4%. (Standard 80%). This is one area where we can improve and take it above 90%. • Outperforming at national and regional (UCLP) level on all published quality indicators. • For the year 8, all cases till NOV 2021 have been completed and locked.		
Neck of Femur Fracture (NOF) Jan- May 2022	Performance – Best Practice Tariff • 97.5% Assessed by Geriatrician in 72hours. • 100% Assessment for bone protection. • 97.5% had Specialist Falls Assessment. Length of stay Overall compared to other local Trusts we are still performing well (only Whittington was 15.5 days for their mean). Homerton also still performing well at discharging our patients back to their original residence; 80% compared to National average of 70%. Theatre delays 4 monthly deep dive to identify improvement.	(1) To update Hip fracture pathway (2) Inpatient falls resulting in Hip Fracture **Theatre Delays** • Documentation of why patient delayed/not suitable for surgery. • List prioritisation • Complex cases/staffing/resources • Perioperative assessment timing	(1) Pathway discussions ongoing. (2) in ED → QI work around highlighting risk of falls. 2-way dialogue between falls and hip fracture group now in place **Theatre Delays** - Early anaesthetic assessment - Education to staff around why hip fractures take priority. - Use of EPR by anaesthetics - Education to orthopaedics to use EPR to document.

JAG Accreditation Report	(1) There was evidence of very supportive general management input to the service. (2) There is strong clinical leadership and the service is congratulated on good governance and a robust audit programme which is published. (3) When interviewed, one patient specifically talked about a staff member 'going the extra mile' to support her in preparing for her colonoscopy and how this gave her the confidence to attend her scheduled appointment. This is an excellent example of compassionate care (4) When producing information leaflets the service sought specific feedback from patients to check that the information provided was clear and presented in a way that was easy to understand. This is excellent practice. (5) There are very good administration induction documents to support new staff appointments and ensure consistency in working practices. (6) The service currently has very short waiting times, with the maximum wait for routine patients of 2-3 weeks. This has been supported by	(1)We recommend that the recovery area could be further improved by replacing the curtains of the pods with doors. This would allow a reuse of some of the current endoscopy space by enabling patients to be confidentially admitted and discharged in their pods. (2)There is a map provided to help patients find their way to the endoscopy department, but signage around the entrance and access lift should be reviewed to make directions clearer, particularly for patients who would prefer to use the stairs rather than the lift. (3)We would recommend a review of the patient booking pathway, specifically for the patients that have not responded to either phone calls or texts. One option could be sending a 'phone in letter' rather than an appointment letter to ensure best use of the available capacity (4)The department may benefit from the employment of a Practice Educator to	

	insourcing which is now able to cease. due to backlog clearance and stability of the current demand vs capacity (7) It is exemplary that the service had made good recovery after COVID in terms of waiting. times and that the insourcing required to achieve this is now stopping. (8) The service has an excellent, well-resourced administration team who were happy in their working environment (9) There is an excellent induction programme in place for nurses and nursing assistants and evidence of signed competencies for all grades of nursing staff. (10) Nursing staff report having good access to both internal and external training. opportunities and are using the JETs workforce platform. (11) The team should be congratulated on the implementation of regular multidisciplinary virtual endoscopy human factors training to support team working and the development of skills. (12) The assessment team congratulate the service on its commitment to training the	support with training and education within the department.	

	trainees. This was demonstrated by the establishment of the endoscopy simulation. courses. It is noted that the trainees are happy and had provided good feedback on. their training opportunities		
National Audit of Care at End of Life	(1) 100% - case notes with an individualised Care Plan of care, recorded a discussion with patient regarding plan of care. (2) 100% Case note recorded discussions with families/carers regarding the possibility the patient may die.	(1) To promote staff confidence, support, and culture.	(1) Trust Education farmwork being devised to empower and promote staff confidence, support, and culture.

Table 14: actions identified from national audit reports

Appendix 3: Actions identified during local clinical audits

AUDIT TITLE	Directorate/ Service	OPPORTUNITIES TO IMPROVE	ACTIONS COMPLETED
What happens to safeguarding referrals by Homerton Healthcare Foundation Trust staff to children's social care	Corporate Nursing/ Safeguarding Children	(1) Audit the 'Quality of referrals sent to the Children Social Care Team (2) obtain outcome of the referrals if in the Paediatric Psychosocial Meeting Children Social Care (CSC) state, it is being screened. (3) Offering support Service	(1) Training for offering support services. • RedThread • Victim Support IDVA • Young Hackney Substance Misuse Team
Information sharing of vulnerable Antenatal women between Maternity and health visiting service	Corporate Nursing/ Safeguarding Children	Systems for effective information sharing should not depend on third party liaison and meeting attendance. For continuity of care and effective support of vulnerable antenatal women further improvements need to be made. (1) The process needs oversight by senior HV's and midwives to ensure referrals are being	(1) HV rapid response hub email set up so referrals are immediately managed on receipt. huh-tr.hvrapidresponse@nhs.net. Referral form updated with the new email address. Named midwife updated via email and verbally of the change in email address.

		completed, uploaded and noted on RIO. (2) The process of information sharing for vulnerable antenatal women needs improvements to ensure there is better recording of the direct liaison between midwives and health visiting service.	(2) HV representative at maternity psychosocial review the weekly list prior to the meeting and update at the meeting if referral not on RIO system.
High Risk Assessments and Risk Reduction Strategies in Sexual Health	CCS/ Homerton Sexual Health Service	Staff Teaching (1) Regular teaching would take place during Wednesday morning CPD sessions. The aim would be to book in these teaching sessions annually for existing staff. For new staff the aim would be for the findings of this audit to be included in the induction teaching sessions. The PowerPoint presentation would also be available on the S drive for new staff to access at any time. (2) Two groups of junior doctors start at the service in both August and February every year. Therefore, junior doctors joining the trust are expected to attend all required teaching as part of their induction. This can also include the results of this audit and the subsequent recommendations. Ad-hoc sessions or self-directed learning via the S drive can also be arranged. Proforma bundle (3) Creation and implementation of a high-risk bundle on proforma. (4) (3) Re-audit post implantation of high-risk bundle on proforma	(1) Outcomes presented and discussed in our team wide CPD meeting. (2) Recommendations for training to new rotating junior doctors joining the service bi-annually as well as signposting to staff to training section of our S-drive for updates. (3) Adaptations to our clinical software to support information gathering/documentation on risk and risk reduction.
Single Anastomosis Gastric Bypass (SAGB)/One Anastomosis	SWNS/ Bariatric Surgery	(1) Multidisciplinary (MDT) Oversight of OAGB Surgery (2) Provision of clear guidance on appropriate BPL (3) Review of Follow Up Process Post OAGB	(1) An independent review of the Bariatric governance structure has been commissioned. (2) patients potentially listed for OAGB must be agreed

Gastric Bypass (OAGB)		(4) Implementation of BOMSS Guidance for all OAGB Patients (5) MDT Oversight of Post Operative Complication in OAGB Patients (6) Bariatric Governance Review (7) Review of Bariatric AHP Structure (8) Further review of Homerton OAGB Patients	by the MDT and the limb length to be offered must be agreed too prior to surgery. (3) redesigned patient pathway built into Electronic Patient Record (EPR) System. (4) The current guidance regarding limb lengths have been incorporated into the pathways and structures as well as dietetic management and follow-up of such patients. (5) The Bariatric AHP structure is also under review. Therapies Lead involved in review to ensure there is robust support structure for HTTPS to escalate their concerns.
Compliance to BOAST guidelines on safe use of tourniquet in orthopaedic surgeries	SWNS/ Trauma & Orthopaedics	(1) To inflate tourniquet at safe pressures (a) Presenting in audit meetings. (b) Posters in theatres. (2) Improve operation note documentation. (a) Add pressure /duration /skin check /shut off / exsanguination to operation note template. (3) Increase awareness of guidelines (a) Presenting in audit meetings. (b) Posters in theatres. (4) To ensure improvement within service	(1) Presented in Audit Meeting Dec 2022 and Posters added to theatres. (2) Operation Note Updated (3) Guideline presented at Audit Meeting Dec 2022 and Posters added to theatres. (4) Reaudit in November 2023 to identify improvement.
3rd Degree Tears on the Birth Centre	SWNS/ Maternity	(1) Improved documentation of perineal support given during delivery. (2) Improve education about use of warm compresses for perineal support. (3) Improve recognition and prevention of PPH.	(1) Include teachings as part of MMT and on birth centre team meetings. (2) Use of support staff to weigh swabs (more support staff availability), escalate in a timely manner.
Transfer Audit for Birth Centre	SWNS/ Maternity	(1) Band 7 reviews in the room prior to transfer 95% of cases. Birth Centre Team leads to attend Band 7 meetings and Matron to support. (2) Present audit to Band 7s.	(1) Band 7 review in the room is ongoing work and continues to be audited. (2) Design course. Commence sessions online initially.

		(3) Design and implement Active Birth workshops aimed at reducing latent phase admissions/transfers.	(3) The Active Birth workshop is ready to roll out when the face-to-face antenatal class returns
Post appendicectomy prolonged hospital stay	SWNS/ General Surgery	(1) All laparoscopic appendectomies to be performed in under 24 hours of diagnosis. (2) To ensure improvement within service by decreasing the patients waiting time for surgery and in-hospital stay	(1) Two full day CEPOD lists (Tuesday & Thursday) introduced. (2) Emergency Appendicectomy Length of Stay is monitored as an ongoing Key Performance Indicator (KPI) for two full day CEPOD list intervention.

Table 15: Outcomes of local clinical audits